

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the deputy medical examiner, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Sacred Heart Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Earl</u> Last <u>Arble</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12-1897</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter & Paper hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Thornton, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jarusia Vandergrift</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Arble Arble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Joseph Vandergrift, Cumberland, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>drowning</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>about</u> <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped of Cumberland & ridgely bridge into Potomac River.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4. 15</u> Hour <u>4. 15</u> p. m. <u>April 25 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac river</u>		20f. (City or town) (County) (State) <u>Cumberland Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 26-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Allegany County Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight, Cumberland, Maryland.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>April 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>	

APR 30 1956

RECEIVED
APR 30 1955

3482

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>1 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>40 Third Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Calvin</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 21, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR: Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>		IF UNDER 24 HRS. Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fort Cumb. Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Hendricks, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert J. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah V. Carr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1918-1921</u>				16. SOCIAL SECURITY NO. <u>214-07-3020</u>		17. INFORMANT <u>Mrs. Evelyn Baker</u> Address <u>40 3rd Ave., Ridgeley W. Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 hour</u> DUE TO (c) <u>1 hour</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>56</u> , and that death occurred at <u>12:15</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>133 Virginia Ave. Cumberland, Md.</u> DATE SIGNED <u>4/16/56</u> ACTUAL SIGNATURE <u>G. Overton Himmelwright, M.D.</u> PHYSICIAN'S NAME (Type) <u>G. Overton Himmelwright, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Ashby, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>April 18, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate and file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3003

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

APR 20 1956

RECEIVED

Form with fields for signature, date, and other administrative information. The text is mostly illegible due to the quality of the scan.

3537
CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport rural		c. LENGTH OF STAY IN 1b 80 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) James William Barnard			4. DATE OF DEATH April 3 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1873	9. AGE (In years lost, birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track-man		10b. KIND OF BUSINESS OR INDUSTRY Coal mine		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Barnard			14. MOTHER'S MAIDEN NAME Mary C. Smiley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. James W. Barnard-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arterial Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic Hypertrophy					INTERVAL BETWEEN ONSET AND DEATH 4 Days 10 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb 15 , 19 56 , to Apr 3 , 19 56 , that I last saw the deceased alive on Apr 1 , 19 56 , and that death occurred at 4:10 P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Paul R. Wilson		M.D. Piedmont, W. Va.		DATE SIGNED 4-6-56	
PHYSICIAN'S NAME (Type) Paul R. Wilson					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/ 56		22c. NAME OF CEMETERY OR CREMATORY Philos Cem.	
22d. LOCATION (City, town, or county) Westernport		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE E.S. Bural - Westernport, Md			24a. REC'D BY REGISTRAR DATE 4-6-56		24b. REGISTRAR'S SIGNATURE Mrs Joan C. Kelly

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 9 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3538

CERTIFICATE OF DEATH

03452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
c. LENGTH OF STAY IN 1b <u>Lifetime</u>				d. STREET ADDRESS <u>7 East Main St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Bath</u> Last <u>Bath</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 23, 1873</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Women's Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Bath</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Warne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>213-05-7092</u>		17. INFORMANT <u>Mrs. Harry Beall</u> Address <u>1 Broadway, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 442X DUE TO <u>Cardiovascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>January, 1956</u> to <u>4/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/22</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hilda Jane Walters</u> M.D.				ADDRESS (Street, city or town, state) <u>48 Broadway, Frostburg, Md.</u> DATE SIGNED <u>4/23/56</u>			
PHYSICIAN'S NAME (Type) <u>Hilda Jane Walters, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg Md.</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah H. Montecant</u> ADDRESS <u>Hafer Funeral Home 23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>4-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nancy N. Roe</u>	

BUREAU V. S.

MAY 1 1953

RECEIVED

3483 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at the Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>122 Independence St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>Richard</u> Last <u>Beavers</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24-1902</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>53</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Vendor Operator -for Maryland</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sterling, Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Beaver</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Reeves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>019-30-6842</u>			
17. INFORMANT <u>(wife) Clara Beavers, Cumberland, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> about <u>3 days</u> DUE TO <u>Ruptured gallbladder</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute pancreatitis</u> (c) <u>also had coronary sclerosis</u> DUE TO <u>5870</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>0</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				DATE SIGNED <u>April 30-1956</u>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Queen's Point Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keyser, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Silcox Funeral Home, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>May 1, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be filed with the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

3484

CERTIFICATE OF DEATH

Reg. Dist. 03454

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNSYLVANIA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CRUMP NURSING HOME</u>		d. STREET ADDRESS <u>TURTLE CREEK</u>	
3. NAME OF DECEASED (Type or print) First <u>AUGUSTUS</u> Middle <u>BERKENBAUGH</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1901</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>for brother-in-law</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>LOUIS BERKENBAUGH</u>		14. MOTHER'S MAIDEN NAME <u>EVA WYPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS EVA BERKENBAUGH, TURTLE CREEK, PA.</u>	
17. INFORMANT <u>MISS EVA BERKENBAUGH, TURTLE CREEK, PA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 5</u> , 19 <u>56</u> , to <u>Apr 9th</u> , 19 <u>56</u> , that I lost saw the deceased alive on <u>April 7</u> , 19 <u>56</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Trevaskis, Sr.</u>		ADDRESS (Street, city or town, state) <u>Cumberland, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>R. W. TREVASKIS, SR.</u>		DATE SIGNED <u>4/11/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-13-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAEL'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FROSTBURG, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DURST</u>		ADDRESS <u>FROSTBURG, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF ASSISTANT CLERK		19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF CLERK IN CHARGE	
21. SIGNATURE OF CLERK IN CHARGE		22. SIGNATURE OF CLERK IN CHARGE		23. SIGNATURE OF CLERK IN CHARGE		24. SIGNATURE OF CLERK IN CHARGE		25. SIGNATURE OF CLERK IN CHARGE	
26. SIGNATURE OF CLERK IN CHARGE		27. SIGNATURE OF CLERK IN CHARGE		28. SIGNATURE OF CLERK IN CHARGE		29. SIGNATURE OF CLERK IN CHARGE		30. SIGNATURE OF CLERK IN CHARGE	
31. SIGNATURE OF CLERK IN CHARGE		32. SIGNATURE OF CLERK IN CHARGE		33. SIGNATURE OF CLERK IN CHARGE		34. SIGNATURE OF CLERK IN CHARGE		35. SIGNATURE OF CLERK IN CHARGE	
36. SIGNATURE OF CLERK IN CHARGE		37. SIGNATURE OF CLERK IN CHARGE		38. SIGNATURE OF CLERK IN CHARGE		39. SIGNATURE OF CLERK IN CHARGE		40. SIGNATURE OF CLERK IN CHARGE	
41. SIGNATURE OF CLERK IN CHARGE		42. SIGNATURE OF CLERK IN CHARGE		43. SIGNATURE OF CLERK IN CHARGE		44. SIGNATURE OF CLERK IN CHARGE		45. SIGNATURE OF CLERK IN CHARGE	
46. SIGNATURE OF CLERK IN CHARGE		47. SIGNATURE OF CLERK IN CHARGE		48. SIGNATURE OF CLERK IN CHARGE		49. SIGNATURE OF CLERK IN CHARGE		50. SIGNATURE OF CLERK IN CHARGE	
51. SIGNATURE OF CLERK IN CHARGE		52. SIGNATURE OF CLERK IN CHARGE		53. SIGNATURE OF CLERK IN CHARGE		54. SIGNATURE OF CLERK IN CHARGE		55. SIGNATURE OF CLERK IN CHARGE	
56. SIGNATURE OF CLERK IN CHARGE		57. SIGNATURE OF CLERK IN CHARGE		58. SIGNATURE OF CLERK IN CHARGE		59. SIGNATURE OF CLERK IN CHARGE		60. SIGNATURE OF CLERK IN CHARGE	
61. SIGNATURE OF CLERK IN CHARGE		62. SIGNATURE OF CLERK IN CHARGE		63. SIGNATURE OF CLERK IN CHARGE		64. SIGNATURE OF CLERK IN CHARGE		65. SIGNATURE OF CLERK IN CHARGE	
66. SIGNATURE OF CLERK IN CHARGE		67. SIGNATURE OF CLERK IN CHARGE		68. SIGNATURE OF CLERK IN CHARGE		69. SIGNATURE OF CLERK IN CHARGE		70. SIGNATURE OF CLERK IN CHARGE	
71. SIGNATURE OF CLERK IN CHARGE		72. SIGNATURE OF CLERK IN CHARGE		73. SIGNATURE OF CLERK IN CHARGE		74. SIGNATURE OF CLERK IN CHARGE		75. SIGNATURE OF CLERK IN CHARGE	
76. SIGNATURE OF CLERK IN CHARGE		77. SIGNATURE OF CLERK IN CHARGE		78. SIGNATURE OF CLERK IN CHARGE		79. SIGNATURE OF CLERK IN CHARGE		80. SIGNATURE OF CLERK IN CHARGE	
81. SIGNATURE OF CLERK IN CHARGE		82. SIGNATURE OF CLERK IN CHARGE		83. SIGNATURE OF CLERK IN CHARGE		84. SIGNATURE OF CLERK IN CHARGE		85. SIGNATURE OF CLERK IN CHARGE	
86. SIGNATURE OF CLERK IN CHARGE		87. SIGNATURE OF CLERK IN CHARGE		88. SIGNATURE OF CLERK IN CHARGE		89. SIGNATURE OF CLERK IN CHARGE		90. SIGNATURE OF CLERK IN CHARGE	
91. SIGNATURE OF CLERK IN CHARGE		92. SIGNATURE OF CLERK IN CHARGE		93. SIGNATURE OF CLERK IN CHARGE		94. SIGNATURE OF CLERK IN CHARGE		95. SIGNATURE OF CLERK IN CHARGE	
96. SIGNATURE OF CLERK IN CHARGE		97. SIGNATURE OF CLERK IN CHARGE		98. SIGNATURE OF CLERK IN CHARGE		99. SIGNATURE OF CLERK IN CHARGE		100. SIGNATURE OF CLERK IN CHARGE	

BUREAU V. S.

APR 13 1956

RECEIVED

Reg. Dist. No.

3549

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b 50 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JANE S. BLAIR		4. DATE OF DEATH 4/19/1956	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept, 9th, 1868	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Stuart		14. MOTHER'S MAIDEN NAME Mary Grey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Chronic nephrosis			
INTERVAL BETWEEN ONSET AND DEATH 2 mos. Several yrs. Several yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 1956 , to April 19, 1956 , that I last saw the deceased alive on April 18, 1956 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED			
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.		Lonaconing, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1956	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		24a. REC'D BY REGISTRAR 4-26-56 24b. REGISTRAR'S SIGNATURE Jannette M. Boal	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. S.

APR 30 1956

RECEIVED

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 15 1891	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
APR 28 1956		BALTIMORE, MARYLAND		100-100000		100-100000	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		PLACE		CAUSE		MANNER	
APR 28 1956		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL	

4

b. COUNTY

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Yes

UNDER 24 HRS

Months	Days	Hours	Min.
--------	------	-------	------

12. CITIZEN OF WHAT COUNTRY?

14 MOTHER'S MAIDEN NAME

FORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

lying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m. 19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(Stole)

21. I certify that I attended the deceased from 4/10, 1956, to 4/13, 1956, that I last saw the deceased alive on 4/12, 1956, and that death occurred at 6:40 P.M. from the causes and on the date stated above.

**ACTUAL
SIGNATURE**

PHYSICIAN'S
NAME (Type)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS _____

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

10

RECEIVED

3539

CERTIFICATE OF DEATH

03457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 8 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAURA Middle BELLE Last BOWMAN		4. DATE OF DEATH Month Apr Day 30 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1887
9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Friddle		14. MOTHER'S MAIDEN NAME Sarah E. Doman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		17. INFORMANT John W. Bowman, Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Depressive Psychosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 77	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 17 , 19 56 , to Apr 30 , 19 56 , that I last saw the deceased alive on Apr 30 , 19 56 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg Md DATE SIGNED Apr 30 1956			
ACTUAL SIGNATURE WOMC Lane M.D.		DATE SIGNED Apr 30 1956	
PHYSICIAN'S NAME (Type) WOMC Lane			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-3-56	22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		24a. REC'D BY REGISTRAR DATE 5-3-56	
ADDRESS Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Wm. Hancy A. Roe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3033

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 1 1956		BALTIMORE		NATURAL	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 1 1956		BALTIMORE		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
RETIRED		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		DATE OF ILLNESS		DATE OF DEATH	
NONE		JAN 1 1956		JAN 1 1956	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DEATH REGISTRAR	
[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 1 1956		JAN 1 1956		JAN 1 1956	

BUREAU V. 1

JAN 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03458

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>15 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Hampshire</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural) Springfield</u> d. STREET ADDRESS <u>85 x -3</u> ✓ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Louis</u> Last <u>Brinker</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>19 56</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16-1889</u>		9. AGE (In years last birthday) <u>66</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>			
13. FATHER'S NAME <u>Mathias Brinker</u>			14. MOTHER'S MAIDEN NAME <u>Louisa Ruppenkamp</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-60-5028</u>		17. INFORMANT <u>(son) Charles W. Brinker</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, Intra-abdominal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ruptured abdominal viscus & lower</u> DUE TO (c) <u>portion of abdominal aorta.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving tractor up decline, upended & fell on him.</u>					
20c. TIME OF INJURY Month, Day, Year <u>3</u> p. m. <u>4-25</u> <u>1956</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Springfield</u> (County) <u>Hampshire</u> (State) <u>W. Va.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 26-1956</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul Cem.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>April 27, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>					

MEDICAL CERTIFICATION

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 30 1956

RECEIVED

3550

CERTIFICATE OF DEATH

03459

Reg. Dist. No. 0

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. LENGTH OF STAY IN 1b 68yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Watercliffe Street				d. STREET ADDRESS Watercliffe Street			
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE ESTHER BRODERICK				4. DATE OF DEATH Month Day Year April 23 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 29.1887	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick Stakem				14. MOTHER'S MAIDEN NAME Catherine E. Cavanaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Address William Broderick, Lonaconing, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 2-4 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Heart Failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 19 19 56 to 23 Apr 19 56 , that I last saw the deceased alive on 23 Apr 19 56 , and that death occurred at 9:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, MD. DATE SIGNED 4-24-56							
ACTUAL SIGNATURE George Eichhorn M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/1956		22c. NAME OF CEMETERY OR CREMATORY ST. Marys Cemetery.		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, MD.			
24a. REC'D BY REGISTRAR DATE 4-26/56				24b. REGISTRAR'S SIGNATURE June M. Pool			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

APR 20 1956

RECEIVED

Name of Deceased		Date of Death	
John Doe		April 15, 1956	
Age		Sex	
65		Male	
Race		Color	
White		White	
Marital Status		Cause of Death	
Married		Heart Disease	
Place of Birth		Place of Death	
Baltimore, Md.		Baltimore, Md.	
Occupation		Signature of Physician	
Teacher		John Doe, M.D.	
Signature of Registrar		Signature of Coroner	
John Doe		John Doe	

Within this State limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03460

3487

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland,</u>		<u>55yrs</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>1314 LaFayette Ave.</u>				<u>1314 LaFayette Ave</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William A. Brown</u>				<u>April 15, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>M.</u>	<u>W</u>	<u>Married</u>	<u>March 4, 1879</u>	<u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Retired Boilermaker Railroad</u>					<u>Dennis N. C.</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wm. F. Brown</u>				<u>Amanda Huggins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>705-12-4634</u>		<u>Wife- Sally Brown 1314 LaFayette</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>422.2</u>				<u>Chronic Myocarditis</u>			
IMMEDIATE CAUSE (A)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15, 1956</u>, to <u>April 15, 1956</u>, that I last saw the deceased alive on <u>April 15, 1956</u>, and that death occurred at <u>6:17</u> M., from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>W. F. Brown</u>		<u>Cumberland, Md.</u>		<u>4-16-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-18-56</u>		<u>Twigg Family Cem.</u>		<u>Near Oldtown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>April 17, 1956</u>		<u>Walter R. Hantz, M.D.</u>		<u>James F. Scarpelli</u>		<u>Cumberland, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. 3

APR 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3488 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03461

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Bedford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville 75x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 D. O. A. at the Sacred Heart Hospital				d. STREET ADDRESS R.F.D. #3, Bedford Valley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle G. Last BRUNER				4. DATE OF DEATH Month APRIL Day 19, Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1881	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bedford Valley, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Levi Hartman			
14. MOTHER'S MAIDEN NAME Mary Smith				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mabel Growden, Bedford Valley, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary sclerosis DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Bethel Methodist Cem.	
22d. LOCATION (City, town, or county) Bedford Valley, Pennsylvania				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.				24a. REC'D BY REGISTRAR April 20, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

03191

BUREAU V. S.

APR 23 1956

RECEIVED

3489

CERTIFICATE OF DEATH

03462

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		MARYLAND		b. COUNTY		ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
02 CUMBERLAND		136 DAYS		CUMBERLAND							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS									
60 MEMORIAL HOSPITAL MEMORIAL AVE.		225 S. MECHANIC ST.									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
MRS HAZEL		B.		BURKE				APRIL 25		19 56	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		APRIL 12 1898		58 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife		Own Home		MARYLAND		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
JOSEPH KRIMM		BERTHA MILLER									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None		MEMORIAL HOSPITAL, CUMBERLAND MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carinoma Breast		INTERVAL BETWEEN ONSET AND DEATH							
170X		DUE TO		2 years							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		generalized metastasis							
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that I attended the deceased from March 1954, to April 25, 1956, that I last saw the deceased alive on April 25, 1956, and that death occurred at 12:20 PM, from the causes and on the date stated above.											
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)		DATE SIGNED							
George M. Simons		128 Union St., Cumberland		4/28/56							
PHYSICIAN'S NAME (Type)		George M. Simons, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
Burial		April 28, 1956		Rose Hill Cemetery		Cumberland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Charles L. George		Cumberland, Md.		April 28, 1956		W. B. Frank, M.D.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the [redacted] hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JESSE W. KILLER		2. SEX MALE		3. AGE 37	
4. RACE WHITE		5. BIRTH DATE 1919		6. BIRTH PLACE INDIANA	
7. OCCUPATION FARMER		8. MARITAL STATUS MARRIED		9. EDUCATION HIGH SCHOOL	
10. PRESENT ADDRESS 1000 S. 10th St., Chicago, Ill.		11. DATE OF DEATH MAY 1, 1956		12. PLACE OF DEATH HOME	
13. CAUSE OF DEATH HEART DISEASE		14. MANNER OF DEATH NATURAL		15. SIGNATURE OF PHYSICIAN J. W. KILLER	
16. SIGNATURE OF WITNESSES J. W. KILLER		17. SIGNATURE OF DECEASED J. W. KILLER		18. SIGNATURE OF REGISTRAR J. W. KILLER	

BUREAU V. S.

MAY 1 1956

RECEIVED

Item 8, Film g 195, 4/10/56 bh

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POINTS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				d. STREET ADDRESS 857.3			
3. NAME OF DECEASED (Type or print) JAMES H. BURKETT				4. DATE OF DEATH APRIL 1 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 1, 1907	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN BURKETT				14. MOTHER'S MAIDEN NAME MARY INSKEEP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart Failure DUE TO (b) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/22 , 19 56 , to 4/1 , 19 56 , that I last saw the deceased alive on 4/1 , 19 56 , and that death occurred at 12:35PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley Jr. M.D. 450 N. Centre St., Cumberland				DATE SIGNED 4/2/56			
PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Points, Hampshire Co., W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley Shaffer ADDRESS Remedy Rd.				24a. REC'D BY REGISTRAR April 3, 1956		24b. REGISTRAR'S SIGNATURE W.R. Brantley M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

YEAR: 1991

• 1910-1911, 1912-1913

445

3114

310

• CM : 00A:02:0002, 14715204_A/0001

BUREAU V.

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03464**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Ma. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany Co. Infirmary				d. STREET ADDRESS 192 Wineow Street			
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last Campbell				4. DATE OF DEATH Month April Day 22 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15-1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 7 Days 19 Hours 56	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hensel				14. MOTHER'S MAIDEN NAME Catherine Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT (husband) James W. Campbell, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion (right) 420.1 DUE TO Cardiac hypertrophy (moderate) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrothorax (bilateral) DUE TO Pulmonary edema (c) Ascities </p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH 10 hrs. ? ? ?</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 22-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 24, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland.				24a. REC'D BY REGISTRAR April 24, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Officer		15. Signature of Cemetery Officer	
16. Signature of Funeral Home		17. Signature of Mortuary		18. Signature of Embalmer	
19. Signature of Burial Society		20. Signature of Cemetery		21. Signature of Burial	
22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
25. Signature of Burial		26. Signature of Burial		27. Signature of Burial	
28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial	
34. Signature of Burial		35. Signature of Burial		36. Signature of Burial	
37. Signature of Burial		38. Signature of Burial		39. Signature of Burial	
40. Signature of Burial		41. Signature of Burial		42. Signature of Burial	
43. Signature of Burial		44. Signature of Burial		45. Signature of Burial	
46. Signature of Burial		47. Signature of Burial		48. Signature of Burial	
49. Signature of Burial		50. Signature of Burial		51. Signature of Burial	
52. Signature of Burial		53. Signature of Burial		54. Signature of Burial	
55. Signature of Burial		56. Signature of Burial		57. Signature of Burial	
58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial	
64. Signature of Burial		65. Signature of Burial		66. Signature of Burial	
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70. Signature of Burial		71. Signature of Burial		72. Signature of Burial	
73. Signature of Burial		74. Signature of Burial		75. Signature of Burial	
76. Signature of Burial		77. Signature of Burial		78. Signature of Burial	
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91. Signature of Burial		92. Signature of Burial		93. Signature of Burial	
94. Signature of Burial		95. Signature of Burial		96. Signature of Burial	
97. Signature of Burial		98. Signature of Burial		99. Signature of Burial	
100. Signature of Burial		101. Signature of Burial		102. Signature of Burial	

BUREAU V. S.

APR 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03465

3492

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS Cresap Park			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LOLA		First LOLA Middle M. Last CLEM		4. DATE OF DEATH Month APRIL Day 29 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1912		9. AGE (In years last birthday) yrs. 43	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W.VA. Brushy Run		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDGAR HEDRICK				14. MOTHER'S MAIDEN NAME PHOEBE YOKUM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Everett W. Clem, Cresaptown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (4th ventricle) 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Apr , 19 56 , to 29 Apr , 19 56 , that I last saw the deceased alive on 29 Apr , 19 56 , and that death occurred at 9:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 4/30/56							
ACTUAL SIGNATURE Fuller B. Whitworth M.D.							
PHYSICIAN'S NAME (Type) Fuller B. Whitworth M.D. Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Bur. Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR May 2, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3493

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 3/27/56		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
f. STREET ADDRESS 51 Boone Street			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Pauline Middle Pearl Last Cline			4. DATE OF DEATH Month April Day 29 Year 19 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11/1926		9. AGE (In years last birthday) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (State or foreign country) West Virginia (Marion County)		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Albert Phillips			14. MOTHER'S MAIDEN NAME Hazel V. Price		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-5596	17. INFORMANT Address P.O. Box 599 Allegany County Infirmary Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Failure 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis (Gen.) DUE TO (c) General carcinomatosis					INTERVAL BETWEEN ONSET AND DEATH 2 mos. 1 week. 6-12 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary leukemia & transition					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/27/56 , 19____, to 4/29/56 , 19____, that I last saw the deceased alive on April 29 , 19____, and that death occurred at 8:55 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED April 30, 1956					
ACTUAL SIGNATURE James E. McLean		M.D. 49 Greene Street			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-2-56	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR May 2, 1956	24b. REGISTRAR'S SIGNATURE W. K. Frantz, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Allegany Maryland Cumberland		Allegany Maryland Cumberland	
51 Boone Street Allegany County, Maryland		51 Boone Street Allegany County, Maryland	
Female White 30	Female White 30	Female White 30	Female White 30
Homerville Albert Phillips Hazel V. Price		Homerville Albert Phillips Hazel V. Price	
U. S. A.		U. S. A.	
F. C. Box 599 Allegany County, Maryland		F. C. Box 599 Allegany County, Maryland	
BUREAU V. S.		BUREAU V. S.	
RECEIVED		RECEIVED	
MAY 4 1956		MAY 4 1956	
Dr. James E. McLean		Dr. James E. McLean	

3551

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>19 days</u>		TOWN <u>State Frostburg</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS <u>Lyric Apts.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Minnie</u> (Middle) <u>D</u> (Last) <u>Condon</u>				<u>April 3</u> <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>March 3 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Micheal Condon</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS (bro.) <u>Joseph M. Condon, same address</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
592X IMMEDIATE CAUSE (A) <u>Chronic Valvular Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arteriosclerosis</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Nephritis</u>				<u>?</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 15, 1956</u> , to <u>April 3, 1956</u> , that I last saw the deceased alive on <u>April 2, 1956</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James M. O'Leary</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Greene St., Frostburg, Md.</u>		DATE SIGNED <u>4-3-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-5-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Dwyer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	
DATE <u>April 5, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

DR. W. F. WMS.

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near CUMBERLAND, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS BRADDOCK ROAD, R.F.D. #5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle Herman Last COOK		4. DATE OF DEATH Month APRIL Day 17 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 18, 1903
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY B&ORR	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES H. COOK		14. MOTHER'S MAIDEN NAME MARTHA DUFFY DUFFY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-05-4982	
17. INFORMANT Address MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rt. Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH One year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4:23, 1955 to 4:17, 1956 , that I last saw the deceased alive on 4:17, 1956 , and that death occurred at 2:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 4788			
ACTUAL SIGNATURE W. F. Williams, M.D.			
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4/20/56	Rose Hill Cemetery	Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		24a. REC'D BY REGISTRAR April 20, 1956 24b. REGISTRAR'S SIGNATURE W. F. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03469

3540

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 160 Frost Ave.				d. STREET ADDRESS 160 Frost Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FRANCIS Last DAVIES				4. DATE OF DEATH Month April Day 21 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-3-1866	
9. AGE (In years lost birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired custodian				10b. KIND OF BUSINESS OR INDUSTRY Lewis Apts.		11. BIRTHPLACE (State or foreign country) Cardiss, Wales	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Wm. Davies				14. MOTHER'S MAIDEN NAME Elizabeth Francis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. James Brode, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1, 1956 , to Apr 21, 1956 , that I last saw the deceased alive on Apr 21, 1956 , and that death occurred at 11:47 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg Md DATE SIGNED Apr 23 1956 ACTUAL SIGNATURE Wm. J. Durst M.D. PHYSICIAN'S NAME (Type) Wm. J. Durst							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-56		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 4-24-56	
				24b. REGISTRAR'S SIGNATURE Wm. Hancey N. Roe			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03470

Reg. Dist. No.

3552

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Cumberland, rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Cumberland, rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Union Grove Road, R.F.D. #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary Elizabeth</u> Middle <u>DeMoss</u> Last <u></u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailorress Clothing Alteration</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hunter J. Shinnolt</u>		14. MOTHER'S MAIDEN NAME <u>Lourissa Briggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-5965</u>	
17. INFORMANT <u>B. W. DeMoss</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/31</u> , 19 <u>52</u> , to <u>4/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>56</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>456 N. Centre St. Cumberland, Md.</u> DATE SIGNED <u>4/8/56</u>			
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u>		M.D. <u>Leo H. Ley Jr. M.D.</u>	
PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR. M.D.</u>		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/10/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>April 10, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3522

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

RECEIVED
APR 11 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03471

9

Reg. Dist. No.

3541

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>1 wk.</u>		TOWN <u>Zihlman</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>THOMAS A. DICKEY</u>				<u>April 29, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>white</u>	<u>married</u>	<u>6-28-1897</u>	<u>58</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>retired miner</u>		<u>coal mines</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Elizabeth Evans</u>				14. MOTHER'S MAIDEN NAME <u>John Wm. Dickey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>WW 1</u>		<u>none</u>			
				<u>Mrs. Florence Dickey, Zihlman, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
525X IMMEDIATE CAUSE (A)				<u>Myocardial Insufficiency</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B)			
STATING UNDERLYING CAUSE LAST, DUE TO				<u>Pulmonary Fibrosis</u>			
				(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 18, 1956</u> to <u>Apr 29, 1956</u> , that I last saw the deceased alive on <u>Apr 28, 1956</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. Lane MD</u>				DATE SIGNED <u>Apr 30 1956</u>			
ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-1-56</u>		<u>F'bg. Memorial Park</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5-1-56</u>		<u>Mrs. Nancy A. Roe</u>		<u>J. R. Durst, Frostburg, Md.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use eye-cure the certificate, with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3542 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03472

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Edward</u> Last <u>Dishong</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1890</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <u>Retired Coal Miner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mining Coal</u>		11. BIRTHPLACE (State or foreign country) <u>Johnstown, Pa.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Dishong</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Orner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-01-3670</u>		17. INFORMANT Address <u>Miners Hospital records, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Pulmonary tuberculosis</u> about <u>9 yrs.</u> Cautions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Silicosis</u> about <u>8 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 7-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-10-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u> ADDRESS <u>Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>4-10-56</u>	24b. REGISTRAR'S SIGNATURE <u>W. Nancy N. Roe</u>		

RECEIVED

3495

CERTIFICATE OF DEATH

DR. R. RHETT RATHBONE

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 11X-2			
3. NAME OF DECEASED (Type or print) First WESLEY Middle A Last FIKE				4. DATE OF DEATH Month APRIL Day 29 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 14, 1889	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME WILLIAM R. KIKE				14. MOTHER'S MAIDEN NAME ELLEN FRANTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-14-0479		17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVEB.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 24, 1956</u> to <u>April 30, 1956</u> , that I last saw the deceased alive on <u>April 29, 1956</u> , and that death occurred at <u>8:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Rhett Rathbone M.D.				ADDRESS (Street, city or town, state) 122 S. Centre St., Cumberland, Md.			
DATE SIGNED May 1, 1956							
PHYSICIAN'S NAME (Type) R. Rhett Rathbone, M. D.				122 S. Centre St., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Sand Spring Cemetery		22d. LOCATION (City, town, or county) (State) Friendsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edmer Hunsberran				ADDRESS Rockover Funeral Home, Markleysburg		24a. REC'D BY REGISTRAR W. L. Frantz, M. D.	
				24b. REGISTRAR'S SIGNATURE May 1, 1956			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3553 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin</u>			c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leslie Henry Fisher</u>				4. DATE OF DEATH Month Day Year <u>April 15 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1908</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk or Timekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>W.Va. Pulp & P.</u>		11. BIRTHPLACE (State or foreign country) <u>Honesdale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Herriett Milton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-07-3437</u>		17. INFORMANT Address <u>(wife) Loretta L. Fisher, Franklin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>April 16, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philo Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. S. Bwal - Westernport, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>4-17-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Thos Jean C. Kelly</u>				DATE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, along with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0053

BUREAU V. S.

APR 19 1956

RECEIVED

3496 CERTIFICATE OF DEATH

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 81 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24. North Waverly Terrace				d. STREET ADDRESS 24 N. Waverly Terrace			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Joseph Last Forebeck				4. DATE OF DEATH Month April Day 27 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 3 1874	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building Houses		11. BIRTHPLACE (State or foreign country) Cumberland, Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph Forebeck				14. MOTHER'S MAIDEN NAME Katherine Armbruster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 220-10-0648		17. INFORMANT Address Mrs. Martha Forbeck, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Uraemia DUE TO Carcinoma of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs (c) 5 yrs							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec. 10, 1955 to Apr. 27, 1956 , that I last saw the deceased alive on Apr. 27, 1956 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett M.D.				ADDRESS (Street, city or town, state) 236 W. 1st St. Cumberland			
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.				DATE SIGNED 4/28/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 30 1956		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. A. Right				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 30, 1956	
24b. REGISTRAR'S SIGNATURE H. A. Right							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

With corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3497 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03476
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>About 250 Ft. east of Williams St.</u>			d. STREET ADDRESS <u>217 Union St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>H</u> Last <u>Friend</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>19 56</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24-1890</u>		9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>yard brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.O.R.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Swanton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John B. Friend</u>			14. MOTHER'S MAIDEN NAME <u>Harriett Comp</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I</u>			16. SOCIAL SECURITY NO. <u>705-12-2578</u>		
17. INFORMANT <u>Mr. Sweitzer, Bedford Rd. Cumberland, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>body severed at upper part of chest.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Freight train ran over him.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Freight train ran over him near William St. crossing.</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Freight train ran over him near William St. crossing.</u>			
20c. TIME OF INJURY Month, Day, Year <u>4-20</u> 19 <u>56</u> Hour <u>4-20</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B&O.R.Ry.</u>	
20f. (City or town) <u>Cumberland</u>		20g. (County) <u>Allegany</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>April 23, 1956</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>George Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Swanton, Maryland.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Silcox Funeral Home, Cumberland, Maryland.</u>			24a. REC'D BY REGISTRAR <u>April 21, 1956</u>		
24b. REGISTRAR'S SIGNATURE <u>H.V. Deming M.D.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BALTIMORE 12
JAN 25 1968

BUREAU V. S.

APR 24 1956

RECEIVED

3498

CERTIFICATE OF DEATH

03477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, 1121702			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 214 Maryland Ave.,				d. STREET ADDRESS 214 Maryland Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RAYMOND Middle HENRY Last GOSS				4. DATE OF DEATH Month April Day 17 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Amusement Co.,		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Charles W. Goss				14. MOTHER'S MAIDEN NAME Margaret M. Main			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-03-8607		17. INFORMANT Mrs. Helen Goss, 214 Maryland Ave. Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma left lower alveolar process							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-23-56 , to 4-17-56 , that I last saw the deceased alive on 4-11-56 , 19 56 , and that death occurred at 10:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4-18-56 DATE SIGNED							
ACTUAL SIGNATURE C. Zimmermann M.D.							
PHYSICIAN'S NAME (Type) C. Zimmermann Cumberland Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 20, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1895		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
1234 BROADWAY		CLOCKMAKER		HEART DISEASE	
AGE		SEX		MARRIAGE	
45		M		MARRIED	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 20 1956		NEW YORK		NATURAL	
TIME OF DEATH		TEMPERATURE		PULSE	
10:00 AM		98.6		60	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE	
JAN 20 1956		10:00 AM		NEW YORK	

BUREAU V. S.

APR 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03478

3554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Avenue		d. STREET ADDRESS Douglas Avenue	
3. NAME OF DECEASED (Type or print) First Sarah Middle Jane Last Gould		4. DATE OF DEATH Month April Day 1 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 12, 1865
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY England	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Gould		14. MOTHER'S MAIDEN NAME Ann Ball	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Olive Orr		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Coronary DUE TO (c) Generalized		INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 5-10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1952 to 1 Apr 1956 , that I last saw the deceased alive on 19 Apr 1956 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 51 Main Lonaconing DATE SIGNED 4-1-56			
ACTUAL SIGNATURE George Eichhorn MD		M.D. 51 Main Lonaconing	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/56	
22c. NAME OF CEMETERY OR CREMATORY Oak HILL		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md	
24a. REC'D BY REGISTRAR DATE 4-4-56		24b. REGISTRAR'S SIGNATURE Janette M. Bood	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		New York City		Heart Disease		New York City		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time		Burial Signature	
Teacher		Married		White		Catholic		High School		None		Natural		Catholic Cemetery		Jan 15, 1956		10:00 AM		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer		Signature of Burial Officer	
Jan 13, 1956		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. S.

APR 13 1956

RECEIVED

3499

CERTIFICATE OF DEATH

03479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last (TWIN #2) BABY BOY HARTMAN				4. DATE OF DEATH Month Day Year APRIL 18 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1956		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min. 12	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL D. HARTMAN				14. MOTHER'S MAIDEN NAME ALMA A. WARNICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) DUE TO Strangulation - 7mo							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial Strangulation from Cord around Neck							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:18 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Fuller B. Whitworth M.D.				PHYSICIAN'S NAME (Type) Fuller B. Whitworth, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Cushman Lanning ADDRESS				24a. REC'D BY REGISTRAR April 19, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8439

DATE OF DEATH APRIL 19 1956		PLACE OF DEATH HOME		MANNER OF DEATH NATURAL	
DECEASED JAMES M. WICK		AGE 70		SEX MALE	
DATE OF BIRTH APRIL 1 1886		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE	
FATHER JAMES M. WICK		MOTHER MARY M. WICK		MARITAL STATUS MARRIED	
OCCUPATION RETIRED		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
PREVIOUS ILLNESS NONE		CAUSE OF DEATH HEART DISEASE		MORBIDITY NONE	
DATE OF EXAMINATION APRIL 19 1956		PLACE OF EXAMINATION HOME		SIGNATURE OF PHYSICIAN JAMES M. WICK	
DATE OF REPORT APRIL 20 1956		PLACE OF REPORT BALTIMORE, MARYLAND		SIGNATURE OF REGISTRAR JAMES M. WICK	

BUREAU V. S.

APR 20 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3500

CERTIFICATE OF DEATH

03480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Cumberland</u>			c. LENGTH OF STAY IN 1b <u>34 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 Sacred Heart Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>Lenwood</u> Last <u>Hartsock</u>			4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Oil</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland</u>	
13. FATHER'S NAME <u>Howard Hartsock</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Weber</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>710</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-26-3495</u>		17. INFORMANT <u>Pt's chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>420.1</u> DUE TO <u>coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>spontaneous pulmonary thrombosis</u> (c) <u>10 yrs</u> <u>1 week</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>spontaneous pulmonary thrombosis, cerebral embolism, cerebral aneurysm</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May, 19 53</u> to <u>April 29, 19 56</u> , that I last saw the deceased alive on <u>April 29, 19 56</u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Ediz. Brings</u>		ADDRESS (Street, city or town, state) <u>55 Greene St. Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>EDIZ. BRINGS</u>		M.D. <u>55 Greene St. Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Bur. Park</u>	
22d. LOCATION (City, town, or county) <u>Cumberland, Maryland</u>		22e. (State) <u>Md.</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>May 2, 19 56</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Grant, M.D.</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3750

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION	
DATE OF FILING		TIME OF FILING		PLACE OF FILING		CITY		STATE		COUNTRY		FILING OFFICE		FILING NUMBER		FILING INDEX	

BUREAU V. S.

MAY 4 1956

RECEIVED

CERTIFICATE OF DEATH

03481

Reg. Dist. No.

3591

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 72 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle ARTHUR Last HOLLAR				4. DATE OF DEATH Month APRIL Day 28 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 26, 1873	
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82		IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-Operator				10b. KIND OF BUSINESS OR INDUSTRY Bottling Company		11. BIRTHPLACE (State or foreign country) PENNA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME GEORGE HOLLAR				14. MOTHER'S MAIDEN NAME NANCY MEASE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-05-8588		17. INFORMANT Memorial Hospital Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Fibrosis with Decompensation DUE TO (c) Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia							INTERVAL BETWEEN ONSET AND DEATH Immediate 73 days ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-16- , 1956 , to 4-28- , 1956 , that I last saw the deceased alive on April 27, 1956 , and that death occurred at 10:05 AM on the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street, Cumberland, Md. DATE SIGNED 4-30-56							
ACTUAL SIGNATURE Samuel M. Jacobson M.D.							
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.				24. REC'D BY REGISTRAR APR 30, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

DECEASED		MARRIAGE		BIRTH	
NAME		LAST NAME		FIRST NAME	
SEX		AGE		DATE OF BIRTH	
RACE		RELIGION		EDUCATION	
OCCUPATION		RESIDENCE		PLACE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
SIGNATURE		DATE		PLACE	

BUREAU V. S.

MAY 1 1935

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03482

3502

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>65 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooks Hotel</u>				d. STREET ADDRESS <u>470 Central Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>F.</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21-1891</u>		9. AGE (In years last birthday) <u>65 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Insulator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Damm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1912-1916</u>		17. INFORMANT <u>(son) Richard Hughes, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Cardiac hypertrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>several years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>April 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Kartz, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, race, and date of death. The form is partially filled out with handwritten text.

BUREAU V. S.

APR 13 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03483

3543

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>5 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>68 W. Main St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u> (Middle) <u>HOCKING</u> (Last) <u>JEFFRIES</u>				(Month) <u>April</u> (Day) <u>1</u> (Year) <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>10-30-1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber yard</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Jeffries</u>				14. MOTHER'S MAIDEN NAME <u>Mary Susan Hocking</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-6693</u>		17. INFORMANT & ADDRESS <u>Charles Jeffries, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>450.0 Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 9</u> , 19 <u>55</u> , to <u>Apr 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 1</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above. SIGNATURE <u>Womcane</u> M.D. ADDRESS <u>Frostburg Md</u> DATE SIGNED <u>4-3-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-3-1956</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4-3-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>			

CERTIFICATE OF DEATH

3548

Form 10-1-55

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF CLERK

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

BUREAU V. S.

APR 9 1955

RECEIVED

9246040402

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy is to be sent to the office of the Coroner of the county in which the death occurred. The certificate is to be filled out in duplicate, and the original is to be retained in the office of the Registrar. The certificate is to be filled out in duplicate, and the original is to be retained in the office of the Registrar. The certificate is to be filled out in duplicate, and the original is to be retained in the office of the Registrar.

3503

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>40 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. STREET ADDRESS <u>109 Chase Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Edmund</u> Middle <u>Joseph</u> Last <u>Kean</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-94</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired store prop.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Paint Business</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland,</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Daniel Kean</u>				14. MOTHER'S MAIDEN NAME <u>Mary Landwehr Kean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No,</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Nancy Kean 109 N. Chase St., Cumberland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>3rd attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-31</u> , 19 <u>56</u> , to <u>4-9</u> , 19 <u>56</u> that I last saw the deceased alive on <u>4-9</u> , 19 <u>56</u> , and that death occurred at <u>2:40 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>L. B. Mathews M.D.</u> M.D. <u>49 Green St. Cumberland Md.</u> PHYSICIAN'S NAME (Type) <u>L. B. Mathews M.D.</u> <u>49 Green St. Cumberland Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Pauls'</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>April 12, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M. D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2503

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF NOTARY		20. SIGNATURE OF OTHER OFFICIALS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3574 CERTIFICATE OF DEATH

03485

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>35 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>572 Cromwell Terrace</u>			d. STREET ADDRESS <u>572 Cromwell Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Elsie Lavene Kilroy</u>			4. DATE OF DEATH <u>April 5 1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frank Clark</u>			14. MOTHER'S MAIDEN NAME <u>Julia Miller</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>E. C. Kilroy Sr. Cumberland, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>155X</u> DUE TO <u>Carcinoma gall bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic</u> DUE TO (c) <u>metastatic</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>3/30</u> , 19 <u>56</u> , to <u>4/5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/5</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>George M. Brown</u>		ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>4/8/56</u>			
PHYSICIAN'S NAME (Type) <u>George M. Simons, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/8/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>April 8, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>

BUREAU V. S.

APR 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. HODGES

3505

CERTIFICATE OF DEATH

03486

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HRS. 29 MIN.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, rural		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL	
d. STREET ADDRESS ROUTE #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BOY Middle KNIPPENBERG Last BOY		4. DATE OF DEATH Month APRIL Day 7 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 7, 1956
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 7 Days 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JEAN L. KNIPPENBERG		14. MOTHER'S MAIDEN NAME MARY R. COLLIER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 7 1/2 Mon. DUE TO Central placenta previa Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - repeated hemorrhage - Caesarian. (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 7, 1956 to April 7, 1956 that I last saw the deceased alive on April 7, 1956 , and that death occurred at 10:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Royce Hodges		DATE SIGNED 4/8/56	
PHYSICIAN'S NAME (Type) W. ROYCE HODGES, M.D.		ADDRESS (Street, city or town, state) Cumberland, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-56	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpetti		24a. REC'D BY REGISTRAR April 9, 1956	
24b. REGISTRAR'S SIGNATURE W. Frank M.D.		25. ADDRESS Cumberland, Md.	

CERTIFICATE OF DEATH

DR. HONOR

3205

ALLICALLY		ALLICALLY	
CHERLAND		CHERLAND	
ROUTE 15		ROUTE 15	
BOY		BOY	
WHITE		WHITE	
APRIL 1, 1956		APRIL 1, 1956	
U.S.A.		U.S.A.	
MARY R. COLLIER		MARY R. COLLIER	
MEMORIAL HOSPITAL - CHERLAND, MO.		MEMORIAL HOSPITAL - CHERLAND, MO.	

BUREAU V. S.

APR 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03487

Reg. Dist. No. 6

3544

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>135 Front Street</u>				STREET ADDRESS <u>135 Front Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Clarissa</u> (First) <u>May</u> (Middle) <u>Kohne</u> (Last)				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 20, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Moorefield, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Whetzell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>				3.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 9, 1956</u> , to <u>April 9, 1956</u> , that I last saw the deceased alive on <u>April 9, 1956</u> , and that death occurred at <u>5pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>James A. Waberton Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Piedmont W. Va.</u>		DATE SIGNED <u>4-11-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Philos</u>		LOCATION (City, town, or county) (State) <u>Westernport, W. Va.</u>	
24. REC'D BY REGISTRAR DATE <u>4-12-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rogers Funeral Home</u>		ADDRESS <u>Keyser, W. Va.</u>	

CERTIFICATE OF DEATH

3544

1. DECEASED'S NAME (Last, first, middle)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF NOTARY

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF DEPUTY SHERIFF

23. SIGNATURE OF JAILER

24. SIGNATURE OF WARDEN

25. SIGNATURE OF CHIEF OF POLICE

26. SIGNATURE OF DEPUTY CHIEF OF POLICE

27. SIGNATURE OF SHERIFF

BUREAU V. S.

APR 13 1956

RECEIVED

NOTIFICATION OF DEATH TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT BY THE REGISTRAR OF DEATHS, STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. THIS FORM IS TO BE FILLED OUT BY THE REGISTRAR OF DEATHS, STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT BY THE REGISTRAR OF DEATHS, STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT BY THE REGISTRAR OF DEATHS, STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

M

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3506 CERTIFICATE OF DEATH

03488

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Allegany		STATE		Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town)		Cumberland		COUNTY		Allegany	
TOWN		10/13/53		CITY (If outside corporate limits, write RURAL and give nearest town)		Frostburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Allegany County Infirmary		STREET ADDRESS		163 McCulloh Street	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
John		A.		Kopper, Sr.		April 6, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Male	White	Widower	5/16/1879	76 yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired - Carpenter - Mining						Czecho Slovakia	
12. CITIZEN OF WHAT COUNTRY?				U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Kopper				Susan Sova			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		212-18-1649 A		Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				Pulmonary Hypostasis			
ANTECEDENT CAUSE(S) DUE TO				Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				General Arteriosclerosis			
STATING UNDERLYING CAUSE LAST. (C)				Diabetes Mellitus			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 13, 1953, to Apr. 6, 1956, that I last saw the deceased alive on Apr. 6, 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
James B. McLean M.D.				49 Greene St. 4-6-56			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4-9-1956		St. Michael's Cemetery		Frostburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
April 7, 1956		Walter R. Lantz, M.D.		J. R. Durst, Frostburg, Md.			

3500 CERTIFICATE OF DEATH

1. PLACE OF BIRTH		2. PLACE OF DEATH	
Allegany		Allegany	
3. DATE OF BIRTH		4. DATE OF DEATH	
October 10, 1923		October 10, 1923	
5. NAME OF DECEASED		6. NAME OF DECEASED	
John A. Popper		John A. Popper	
7. SEX		8. SEX	
Male		Male	
9. RACE		10. RACE	
White		White	
11. OCCUPATION		12. OCCUPATION	
Farmer - Carpenter - Miner		Farmer - Carpenter - Miner	
13. CAUSE OF DEATH		14. CAUSE OF DEATH	
George Popper		George Popper	
15. PLACE OF BURIAL		16. PLACE OF BURIAL	
Allegany County Infirmary		Allegany County Infirmary	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF PHYSICIAN	
George Popper		George Popper	
19. SIGNATURE OF WITNESSES		20. SIGNATURE OF WITNESSES	
Susan Gove		Susan Gove	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
George Popper		George Popper	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
George Popper		George Popper	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED	
George Popper		George Popper	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
George Popper		George Popper	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
George Popper		George Popper	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
George Popper		George Popper	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED	
George Popper		George Popper	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
George Popper		George Popper	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED	
George Popper		George Popper	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
George Popper		George Popper	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
George Popper		George Popper	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
George Popper		George Popper	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED	
George Popper		George Popper	
47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
George Popper		George Popper	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
George Popper		George Popper	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
George Popper		George Popper	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
George Popper		George Popper	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED	
George Popper		George Popper	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED	
George Popper		George Popper	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
George Popper		George Popper	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED	
George Popper		George Popper	
63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED	
George Popper		George Popper	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
George Popper		George Popper	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
George Popper		George Popper	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
George Popper		George Popper	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
George Popper		George Popper	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED	
George Popper		George Popper	
75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED	
George Popper		George Popper	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
George Popper		George Popper	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
George Popper		George Popper	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED	
George Popper		George Popper	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
George Popper		George Popper	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED	
George Popper		George Popper	
87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED	
George Popper		George Popper	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
George Popper		George Popper	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
George Popper		George Popper	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED	
George Popper		George Popper	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
George Popper		George Popper	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
George Popper		George Popper	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	
George Popper		George Popper	

RECEIVED
BUREAU V. S.
 APR 10 1956

RECEIVED

3507

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY	
d. NAME OF HOSPITAL (If not in hospital, give place of death) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle SCOTT Last LANDIS				4. DATE OF DEATH Month APRIL Day 2 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1874	
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) W.VA., GRANT COUNTY	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ABRAHAM F. LANDIS				14. MOTHER'S MAIDEN NAME ELIZA BORROR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 3/31 , 19 56 , to 4/2 , 19 56 , that I last saw the deceased alive on 4/2 , 19 56 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland MD DATE SIGNED							
ACTUAL SIGNATURE George M. Simons M.D.							
PHYSICIAN'S NAME (Type) GEORGE M. SIMONS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF April 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Indian Mound Cemetery		22d. LOCATION (City, town, or county) (State) Romney, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Keith S. Shaffer				ADDRESS Romney MD		24a. REC'D BY REGISTRAR April 4, 1956	
				24b. REGISTRAR'S SIGNATURE W.R. Frantz M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED

APR 5 1956

BUREAU V. S.

DR. HIMMELWRIGHT 3508 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 434 RACE STREET			
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last LEPLEY				4. DATE OF DEATH Month APRIL Day 21 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 26 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 3 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) MARYLAND Oldtown	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME David STUMP				14. MOTHER'S MAIDEN NAME Chloe McCulley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL - WARWICK & MEMORIAL AVES.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiac Vascular Disease DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec , 1955, to April , 1956, that I last saw the deceased alive on April 21 , 1956, and that death occurred at 4:36 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Overton Himmelwright, M.D.				ADDRESS (Street, city or town, state) 133 Virginia Ave., Cumberland, Md.			
DATE SIGNED 4/22/56							
PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D.				133 Virginia Ave., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 24, 1956	
				24b. REGISTRAR'S SIGNATURE Winters R. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

.. APR 25 1956

BUREAU V. S.

MEMORIAL HOSPITAL - WARWICK & MEMORIAL WED.

STATE

MARYLAND

U. S. A.

WHITE

FEEL

LETTER

APRIL

21

MEMORIAL HOSPITAL

101 RACE STREET

ALLIANCE

WAYS

CHARLES

ALLIANCE

CERTIFICATE OF DEATH

3508

DR. H. H. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3509

CERTIFICATE OF DEATH

03492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>10 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D.O.A. Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Levin</u> Last <u>Levin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Lansman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harry Stein</u> Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident (Hemorrhage)</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>October 3, 1955</u> , to <u>April 26, 1956</u> , that I last saw the deceased alive on <u>April 24, 1956</u> , and that death occurred at <u>6:00PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>50 Pershing Street</u> DATE SIGNED <u>April 27, 1956</u>							
ACTUAL SIGNATURE <u>Samuel M. Jacobson</u> M.D.				PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M.D.</u> <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Phil 27, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W.L. Frantz, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 30 1955

3555

CERTIFICATE OF DEATH

Reg. Dist. No.

8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Marys Terrace				d. STREET ADDRESS St Marys Terrace			
3. NAME OF DECEASED (Type or print) Michael A. Marley				4. DATE OF DEATH Month April Day 3 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1878		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Marley				14. MOTHER'S MAIDEN NAME Mary Ann McPartland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 179-03-4995		17. INFORMANT William Marley Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2d. 4-5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumopneumonia - Resolving						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 52 , to 39 , 19 56 , that I last saw the deceased alive on 39 , 19 56 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED George Eichhorn							
ACTUAL SIGNATURE George Eichhorn M.D.				PHYSICIAN'S NAME (Type) Lonaconing, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1956		22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.				24a. REC'D BY REGISTRAR 4-6-56		24b. REGISTRAR'S SIGNATURE Janette M. Pool	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0

BUREAU V. S.

APR 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS	
CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF DEATH		SIGNATURE OF EXAMINER		DATE	
FINDINGS AT AUTOPSY		HISTORICAL DATA		LABORATORY TESTS		POST-MORTEM FINDINGS		OTHER INFORMATION		REMARKS	

BUREAU V. S.

APR 20 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. **03495**

3545

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 66 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 178 Main St.			d. STREET ADDRESS 178 Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle Seymour Last Mayhew			4. DATE OF DEATH Month April Day 1 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1889		9. AGE (In years lost birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Westernport	
13. FATHER'S NAME James Mayhew			14. MOTHER'S MAIDEN NAME Amanda Sperling		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-03-7796A		17. INFORMANT Address Mrs. Frank Mayhew, Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 Day 2 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 25 , 19 56 , to Apr. 1 , 19 56 , that I last saw the deceased alive on Mar. 31 , 19 56 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED 4-2-56					
ACTUAL SIGNATURE Paul R. Wilson		M.D. Piedmont, W. Va.			
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.		Piedmont W. Va.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/56		22c. NAME OF CEMETERY OR CREMATORY Bloomington	
				22d. LOCATION (City, town, or county) (State) Bloomington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Ellsworth-S. Bual - Westernport			ADDRESS Westernport		24a. REC'D BY REGISTRAR DATE 4-2-56
					24b. REGISTRAR'S SIGNATURE Miss Jean C. Kelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3212

Name of Deceased		Sex		Age		Date of Birth	
Race		Marital Status		Occupation		Place of Birth	
Usual Residence		Cause of Death		Date of Death		Time of Death	
Place of Death		Physician's Signature		Hospital or Clinic		City and State	
County		Municipality		Zip Code		Registrar's Signature	
Date of Report		Reported by		Relationship to Deceased		Signature	

BUREAU V. S.

APR 7 1956

RECEIVED

3511

CERTIFICATE OF DEATH

Reg. Dist. No. 03496

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 2hr 40 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 20 South Street			
3. NAME OF DECEASED (Type or print) First Mary Middle Grace Last Mc Dermott				4. DATE OF DEATH Month 4/ Day 24/ Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/85	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland, Cumberland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Nelson Long				14. MOTHER'S MAIDEN NAME Elizabeth Mc Coll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chart James L. McDermott Address 120 South S			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-9-56 , 19 56 , to 4-24-56 , 19 56 , that I last saw the deceased alive on 4-24-56 , 19 56 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Z. MERMANN				ADDRESS (Street, city or town, state) 105 S Btr			
PHYSICIAN'S NAME (Type) C. Z. MERMANN				DATE SIGNED 4-25-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-56		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Seapelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 26, 1956	
				24b. REGISTRAR'S SIGNATURE W. Frank M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 27 1956

RECEIVED

3512

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			c. LENGTH OF STAY IN 1b <u>2 hrs. 50 min.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>JUDY BARBARA McFARLANE</u>			4. DATE OF DEATH Month Day Year <u>4-24-56</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1948</u>		9. AGE (In years lost birthday) <u>7</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>DAVID McFARLANE</u>			14. MOTHER'S MAIDEN NAME <u>HELEN KERSHEN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>David McFarlane</u> Address <u>705 Gephart Drive Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myo-endocarditis</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sore throat</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-22-</u> , 19 <u>56</u> , to <u>4-24-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-24-56</u> , 19 <u>56</u> , and that death occurred at <u>11th</u> A. M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>L. Brings</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>57 Greene St. Cumberland Md 4-24-56</u>			
PHYSICIAN'S NAME (Type) <u>L. BRINGS, M.D.</u>		<u>57 GREEN ST., CUMBERLAND, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>CUMBERLAND, MD.</u>		24a. REC'D BY REGISTRAR <u>April 28, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Winter L. Frantz, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3232

SEE OUR 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH May 1, 1950		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH St. Louis, Missouri	
7. OCCASION OF DEATH Suicide		8. CAUSE OF DEATH Gunshot wound		9. MANNER OF DEATH Suicide	
10. SIGNATURE OF DECEASED (None)		11. SIGNATURE OF WITNESS (None)		12. SIGNATURE OF PHYSICIAN (None)	
13. SIGNATURE OF CORONER (None)		14. SIGNATURE OF JURY (None)		15. SIGNATURE OF JUDGE (None)	
16. SIGNATURE OF DISTRICT ATTORNEY (None)		17. SIGNATURE OF CLERK (None)		18. SIGNATURE OF REGISTRAR (None)	
19. SIGNATURE OF SHERIFF (None)		20. SIGNATURE OF JAILER (None)		21. SIGNATURE OF PRISON WARDEN (None)	
22. SIGNATURE OF CHIEF OF POLICE (None)		23. SIGNATURE OF DISTRICT CLERK (None)		24. SIGNATURE OF COUNTY CLERK (None)	
25. SIGNATURE OF STATE CLERK (None)		26. SIGNATURE OF FEDERAL CLERK (None)		27. SIGNATURE OF NATIONAL CLERK (None)	
28. SIGNATURE OF INTERNATIONAL CLERK (None)		29. SIGNATURE OF UNITED NATIONS CLERK (None)		30. SIGNATURE OF WORLD CLERK (None)	

BUREAU V. S.

MAY 1 1950

RECEIVED

03498

3513 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>2yr. 0mo. 7da.</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sylvan Retreat</u>				<u>227 Offutt St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mae Lee McETRICK</u>				<u>April 7 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>W</u>	<u>Feb. 19, 1871</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife - Own Home</u>					<u>Loudon, Virginia</u>		<u>U. S. A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Holt</u>				<u>Adeline Blanchard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Addie M. Lewis, 227 offutt St., Cumb.Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 25, 19 53</u> to <u>Apr 7th, 19 56</u> , that I last saw the deceased alive on <u>Apr 7th, 19 56</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>James E. McLean</u> M.D.				<u>49 Greene St.</u> <u>4-8-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 10, 1956</u>		<u>St. John's Cemetery</u>		<u>Ellicott City, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>April 9, 1956</u>		<u>Winter R. Frantz, M.D.</u>		<u>James F. Scarpelli, Cumberland, Maryland.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

APR 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician, and completely filled in by the funeral director, or the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

Without corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3514

CERTIFICATE OF DEATH

03499
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA.		b. COUNTY HARDY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN IB 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD		857-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE		First NELLIE		Middle F.		Last MC NEILL	
4. DATE OF DEATH APRIL 18 1956		Month APRIL		Day 18		Year 1956	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 1, 1908	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 47		IF UNDER 24 HRS. Days 47		Hours 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HYDER SAVILLE				14. MOTHER'S MAIDEN NAME EMILY MESSICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular Disease DUE TO (c) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH 4 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Rheumatic Heart Disease, mitral, inactive		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 18 am., 1956 , that I last saw the deceased alive on 18 am. 56 , 19 56 , and that death occurred at 8:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer		M.D. Cumberland, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Moorefield, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Keith Stapp		ADDRESS Romney, W. Va.		24a. REC'D BY REGISTRAR April 19, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

YAGCI

1917

— 111 —

BUREAU V. S.

APR 20 1956

RECEIVED

CERTIFICATE OF DEATH

03500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DAVID MILLER				4. DATE OF DEATH Month Day Year April 7th. 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb, 2 nd. 1875	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Scotland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Miller				14. MOTHER'S MAIDEN NAME Isabelle Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 17. INFORMANT Address 164-10-3066 Mrs. Henry Meek, R.F.D. # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c) Cerebral						INTERVAL BETWEEN ONSET AND DEATH 3-4 week 4-5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1954 , to April 7, 1956 that I last saw the deceased alive on April 7, 1956 and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED 4-7-56							
ACTUAL SIGNATURE George J. Richards, Jr. M.D.				PHYSICIAN'S NAME (Type) George J. Richards, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Savage Cemetery.		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn,				ADDRESS Lonaconing, MD.		24a. REC'D BY REGISTRAR April 9, 1956 24b. REGISTRAR'S SIGNATURE W. A. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death	
John Doe		45		Male		White		Jan 1, 1910		Jan 15, 1955		Home		Heart Disease	
Occupation		Education		Marital Status		Usual Residence		Usual Address		Usual Telephone		Usual Hospital		Usual Physician	
Teacher		High School		Married		123 Main St.		Baltimore, Md.		555-1234		St. Mary's		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family		Signature of Friend		Signature of Neighbor		Signature of Other	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

APR 10 1956

RECEIVED

3516

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>				c. LENGTH OF STAY IN 1b <u>3 Hr.-45 Min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Barbon</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/7/1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Martha McGinnsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Pt.'s Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>18 hrs.</u> <u>3-5 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>15 April</u> , 19 <u>56</u> that I last saw the deceased alive on <u>15 April</u> , 19 <u>56</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Lonaconing, Md.</u> DATE SIGNED <u>4-16-56</u> ACTUAL SIGNATURE <u>George J. Richards</u> M.D. PHYSICIAN'S NAME (Type) <u>George J. Richards, M.D.</u> <u>Lonaconing, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Moscow, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boals</u>				ADDRESS <u>Westernport, Md.</u>		24a. REC'D BY REGISTRAR <u>April 17, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W.R. Franz, M.D.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for a period of 10 years after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3518

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 38

STATE OF MARYLAND

1951

BUREAU V. S.

APR 18 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3517

CERTIFICATE OF DEATH

Reg. Dist. No.

035024

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keyser, W. Va.</u>			
c. LENGTH OF STAY IN 1b <u>1 Hr-55 Min</u>				d. STREET ADDRESS <u>196 Armstrong St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>April</u> , Day <u>15</u> , Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/56</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours <u>1</u> Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Lloyd Mills</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Katherine Norris</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mother's Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature Rupture Membrane</u> (c) <u>Premature Rupture Membrane</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>F. B. Whitworth</u> M.D.							
PHYSICIAN'S NAME (Type) <u>F. B. Whitworth, M.D.</u> <u>123 Bedford Street, Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Queen's Point Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keyser, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roger Funeral Home Keyser W. Va.</u>				ADDRESS <u>Keyser, W. Va.</u>		24a. REC'D BY REGISTRAR <u>April 19, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W. R. Prantz, M.D.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3513

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		65		M		W		1891		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
RETIRED		HIGH SCHOOL		MARRIED		METHODIST		APR 10 1956		BALTIMORE		MD		USA		USA	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY		STATE		COUNTRY	
HEART DISEASE		NATURAL		15		15		APR 10 1956		BALTIMORE		MD		USA		USA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. S.

APR 20 1956

RECEIVED

3518

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>40 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>144. Frederick St</u>				d. STREET ADDRESS <u>144. Frederick St</u>			
3. NAME OF DECEASED (Type or print) First <u>Annetta</u> Middle <u>E.</u> Last <u>Montgomery</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 12 1879</u>		9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own House</u>		11. BIRTHPLACE (State or foreign country) <u>Burlington, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Taylor Oats</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Oats</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles P. Montgomery, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Mediastinum with Metastases</u> <u>164X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1955</u> to <u>April 1956</u> , that I last saw the deceased alive on <u>April 8, 1956</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Johnson, Jr.</u>				DATE SIGNED <u>April 20, 1956</u>			
PHYSICIAN'S NAME (Type) <u>James T. Johnson, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 21 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Knight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>W.L. Frank, M.D.</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3518

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES H. HARRIS		Male		45		1910		Maryland		Farmer	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
April 23, 1956		10:30 AM		Home		Heart Disease		Natural		J. H. Harris	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CLERK		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF DECEASED		18. SIGNATURE OF SURVIVOR	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. 81

APR 23 1956

RECEIVED

3556

CERTIFICATE OF DEATH

Reg. Dist. No.

03504

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep			c. LENGTH OF STAY IN TB 45 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10			d. STREET ADDRESS Nikep		
3. NAME OF DECEASED (Type or print) First Cecil Middle E. Last Munson			4. DATE OF DEATH Month April Day 26 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1910		9. AGE (In years lost birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	11. BIRTHPLACE (State or foreign country) Nikep, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joshua Munson			14. MOTHER'S MAIDEN NAME Elizabeth Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 232-01-1313	17. INFORMANT Address Daisy Munson Nikep, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 415X DUE TO Chronic Myocarditis and Myocardial Deficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Specified as Rheumatic DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 2 Months 34 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. p. None 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 25, 1956 , to April 26, 1956 , that I last saw the deceased alive on April 24, 1956 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Paul B. Wilson		M.D. Piedmont, W. Va		DATE SIGNED Apr. 26, 1956	
PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill	
				22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn			ADDRESS Lonaconing, Md.		
24a. REC'D BY REGISTRAR 4-28-56		24b. REGISTRAR'S SIGNATURE Jannette M Boal			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3256

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death	
John Doe		45 yrs		Male		White		Married		Teacher		Heart Disease		April 15, 1930		Home	
Name of Informant		Relationship		Address		City		State		Zip		Signature of Informant		Signature of Registrar		Official Seal	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21201		[Signature]		[Signature]		[Seal]	
Physician's Name		Address		City		State		Zip		Signature of Physician		Signature of Coroner		Signature of Burial Officer		Official Seal	
Dr. Smith		456 Oak St		Baltimore		Maryland		21201		[Signature]		[Signature]		[Signature]		[Seal]	
Burial Place		Date of Burial		Signature of Burial Officer		Signature of Coroner		Signature of Physician		Signature of Informant		Signature of Registrar		Signature of Burial Officer		Official Seal	
St. Mary's Church		April 18, 1930		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Seal]	

BUREAU V. S.

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George Robinson, Baltimore, Md.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03505

CERTIFICATE OF DEATH

Within corporate limits 3519

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>3Yrs</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>758 Fayette St.</u>				STREET ADDRESS (If rural give location) <u>758 Fayette St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Grace</u> (Middle) <u>Elizabeth</u> (Last) <u>Murray</u>				(Month) <u>April</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>10/7/1913</u>	<u>42</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Office Work</u>		<u>Newspaper</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Coleman</u>				<u>Anna Decker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u> (If Yes, give war or dates of service)		<u>217 10 1061</u>		<u>Walter Murray Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arteriosclerosis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Anterior Myocardial Infarction</u>						<u>1 1/2 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1-56</u> , 19 <u>56</u> , to <u>4-13-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-13-56</u> , 19 <u>56</u> , and that death occurred at <u>10 p.m.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
<u>James Jacobson</u>		<u>M.D. 50 Pershing St., Cumberland, Md.</u>				<u>4-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/16/56</u>		<u>St. Peter & Paul</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Apr. 16, 1956</u>		<u>W. R. Granty, M.D.</u>		<u>Louis Stein, Inc.</u>		<u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

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BUREAU V. S.

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DR. LEY

3520

CERTIFICATE OF DEATH

Reg. Dist. No.

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1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL				d. STREET ADDRESS 16 W. FIRST ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PATRICK Middle O. Last MYERS				4. DATE OF DEATH Month APRIL Day 7 Year 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 14, 1891	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Labor				10b. KIND OF BUSINESS OR INDUSTRY Orchard Industry			
11. BIRTHPLACE (State or foreign country) W.V A. Greenspring				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILSON WALSON MYERS				14. MOTHER'S MAIDEN NAME ELSIE STANFORD STOTTLEBERG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none			
17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/5 , 19 56 , to 4/7 , 19 56 , that I last saw the deceased alive on 4/7 , 19 56 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Centre St. DATE SIGNED 4/8/56 ACTUAL SIGNATURE Leo H. Ley, Jr. M.D. 456 N. Centre St. PHYSICIAN'S NAME (Type) Leo H. Ley, Jr., M.D. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		22d. LOCATION (City, town, or county) (State) Spring Ga., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR April 9, 1956		24b. REGISTRAR'S SIGNATURE W. H. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film G196 5-7-56 ams

03507

CERTIFICATE OF DEATH

3546

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>West Virginia</u>		COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		LENGTH OF STAY (in this place) <u>3 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Keyser</u>		TOWN <u>Keyser</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>503 Maryland Avenue</u>				STREET ADDRESS (If rural give location) <u>Route #2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Frances</u>		(Middle) <u>Eve</u>		(Last) <u>Parrill</u>		(Month) <u>April</u> (Day) <u>26</u> (Year) <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 14, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mineral Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Stagg</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ravenscroft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Lee Maphis, Westernport, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
904.0 IMMEDIATE CAUSE (A) <u>anemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Fried Hip</u>						<u>April 2 '56</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>W. Va.</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>4-25-56</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Trying to get from bed to bath room.</u>			
22. I hereby certify that I attended the deceased from <u>4-25-56</u> to <u>4-26-56</u> , that I last saw the deceased alive on <u>4-25-56</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>4-26-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cabin Run</u>		LOCATION (City, town, or county) (State) <u>Keyser W. Va.</u>	
24. REC'D BY REGISTRAR DATE <u>4-27-56</u>		REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Rogers Funeral Home Keyser, W. Va.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

File No. 100-100000

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3521

CERTIFICATE OF DEATH

Reg. Dist. No.

035084

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 6 WEST THIRD STREET			
3. NAME OF DECEASED (Type or print) First FRANK Middle PIROLOZZI Last PIROLOZZI				4. DATE OF DEATH Month APRIL Day 10 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 21 1912	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Labor		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME BENEDOTTO PIROLOZZI				14. MOTHER'S MAIDEN NAME CLEMENTINE DI CIZZO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEART DISEASE 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY FIBROSIS + EMPHYSEMA 30 Y AND PULMONARY TUBERCULOSIS - BILAT ?							INTERVAL BETWEEN ONSET AND DEATH 10 Y
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute CIRRHOSIS OF THE LIVER 1YR							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 49 , to 10 APR 19 56 , that I last saw the deceased alive on 9 APR 19 56 , and that death occurred at 6 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 GREENE ST CUMBERLAND MD. DATE SIGNED 10 APR 56							
ACTUAL SIGNATURE ABernstein		M.D. 59 GREENE ST CUMBERLAND MD.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-56		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 13, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

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BUREAU V. S.

APR 13 1956

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rt #2, Frostburg, rural</u> TOWN <u>Frostburg</u> STREET ADDRESS <u>Eckhart</u>								
3. NAME OF DECEASED (Type or Print) <u>Stanley George Porter</u>			4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1956</u>									
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/20/85</u>	9. AGE last birthday <u>70</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired blacksmith - Consolidated Coal Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>								
13. FATHER'S NAME <u>George Porter</u>			14. MOTHER'S MAIDEN NAME <u>Helen Higgins</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Chart</u>		17. INFORMANT & ADDRESS <u>by neighbor</u>								
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 177X IMMEDIATE CAUSE (A) <u>Cancer of prostate</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST. (C)					INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.												
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?								
22. I hereby certify that I attended the deceased from <u>Nov 15, 1955</u> , to <u>Apr 10, 1956</u> , that I last saw the deceased alive on <u>Apr 9, 1956</u> , and that death occurred at <u>12:55 P.</u> M, from the causes and on the date stated above. SIGNATURE <u>R. W. Prevaskis, Dr</u> M.D. <u>Cumberland, Maryland</u> DATE SIGNED <u>4/11/56</u>												
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 13, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>								
24. REC'D BY REGISTRAR <u>April 12, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DURST</u>								
				ADDRESS <u>FROSTBURG, MD.</u>								

CERTIFICATE OF DEATH

3533

Reg. (Stat. No.)

1. REPORT REGISTRATION NUMBER ON DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. DATE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF STATE

24. SIGNATURE OF NATION

25. SIGNATURE OF WORLD

26. SIGNATURE OF UNIVERSE

27. SIGNATURE OF GOD

28. SIGNATURE OF HEAVEN

29. SIGNATURE OF EARTH

30. SIGNATURE OF FIRE

31. SIGNATURE OF WATER

32. SIGNATURE OF AIR

33. SIGNATURE OF LIGHT

34. SIGNATURE OF DARKNESS

35. SIGNATURE OF LIFE

36. SIGNATURE OF DEATH

37. SIGNATURE OF HOPE

38. SIGNATURE OF FEAR

39. SIGNATURE OF LOVE

40. SIGNATURE OF HATE

41. SIGNATURE OF PITY

42. SIGNATURE OF PRIDE

43. SIGNATURE OF HUMILITY

44. SIGNATURE OF COURAGE

45. SIGNATURE OF COWARDICE

46. SIGNATURE OF FAITH

47. SIGNATURE OF DOUBT

48. SIGNATURE OF TRUTH

49. SIGNATURE OF LIES

50. SIGNATURE OF JUSTICE

51. SIGNATURE OF INJUSTICE

52. SIGNATURE OF MERCY

53. SIGNATURE OF CRUELTY

54. SIGNATURE OF KINDNESS

55. SIGNATURE OF UNKINDNESS

56. SIGNATURE OF GENTLENESS

57. SIGNATURE OF RAGGEDNESS

58. SIGNATURE OF SMOOTHNESS

59. SIGNATURE OF CLEANLINESS

60. SIGNATURE OF DIRTYNESS

61. SIGNATURE OF ORDER

62. SIGNATURE OF DISORDER

63. SIGNATURE OF BEAUTY

64. SIGNATURE OF UGLINESS

65. SIGNATURE OF VIRTUE

66. SIGNATURE OF VICE

67. SIGNATURE OF GOODNESS

68. SIGNATURE OF EVILNESS

69. SIGNATURE OF WISDOM

70. SIGNATURE OF FOOLISHNESS

71. SIGNATURE OF STRENGTH

72. SIGNATURE OF WEAKNESS

73. SIGNATURE OF RICHES

74. SIGNATURE OF POVERTY

75. SIGNATURE OF HONOR

76. SIGNATURE OF DISHONOR

77. SIGNATURE OF GLORY

78. SIGNATURE OF SHAME

79. SIGNATURE OF PRAISE

80. SIGNATURE OF REPROACH

81. SIGNATURE OF FAME

82. SIGNATURE OF OBSCURITY

83. SIGNATURE OF RESPECT

84. SIGNATURE OF CONTEMPT

85. SIGNATURE OF ADMIRATION

86. SIGNATURE OF DERISION

87. SIGNATURE OF REVERENCE

88. SIGNATURE OF DESPISE

89. SIGNATURE OF WORSHIP

90. SIGNATURE OF BLASPHEMY

91. SIGNATURE OF OBEDIENCE

92. SIGNATURE OF DISOBEDIENCE

93. SIGNATURE OF PATIENCE

94. SIGNATURE OF IMPATIENCE

95. SIGNATURE OF MILDNESS

96. SIGNATURE OF HARSHNESS

97. SIGNATURE OF SWEETNESS

98. SIGNATURE OF BITTERNESS

99. SIGNATURE OF LIGHTNESS

100. SIGNATURE OF HEAVINESS

101. SIGNATURE OF FREEDOM

102. SIGNATURE OF SLAVERY

103. SIGNATURE OF VICTORY

104. SIGNATURE OF DEFEAT

105. SIGNATURE OF TRIUMPH

106. SIGNATURE OF DISASTER

107. SIGNATURE OF SUCCESS

108. SIGNATURE OF FAILURE

109. SIGNATURE OF HAPPINESS

110. SIGNATURE OF UNHAPPINESS

111. SIGNATURE OF JOY

112. SIGNATURE OF GRIEF

113. SIGNATURE OF PEACE

114. SIGNATURE OF WAR

115. SIGNATURE OF LOVE

116. SIGNATURE OF HATE

117. SIGNATURE OF KINDNESS

118. SIGNATURE OF CRUELTY

119. SIGNATURE OF GENTLENESS

120. SIGNATURE OF RAGGEDNESS

121. SIGNATURE OF SMOOTHNESS

122. SIGNATURE OF CLEANLINESS

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161. SIGNATURE OF BITTERNESS

162. SIGNATURE OF LIGHTNESS

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164. SIGNATURE OF FREEDOM

165. SIGNATURE OF SLAVERY

166. SIGNATURE OF VICTORY

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170. SIGNATURE OF SUCCESS

171. SIGNATURE OF FAILURE

172. SIGNATURE OF HAPPINESS

173. SIGNATURE OF UNHAPPINESS

174. SIGNATURE OF JOY

175. SIGNATURE OF GRIEF

176. SIGNATURE OF PEACE

177. SIGNATURE OF WAR

178. SIGNATURE OF LOVE

179. SIGNATURE OF HATE

180. SIGNATURE OF KINDNESS

181. SIGNATURE OF CRUELTY

182. SIGNATURE OF GENTLENESS

183. SIGNATURE OF RAGGEDNESS

184. SIGNATURE OF SMOOTHNESS

185. SIGNATURE OF CLEANLINESS

186. SIGNATURE OF DIRTYNESS

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194. SIGNATURE OF EVILNESS

195. SIGNATURE OF WISDOM

196. SIGNATURE OF FOOLISHNESS

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198. SIGNATURE OF WEAKNESS

199. SIGNATURE OF RICHES

200. SIGNATURE OF POVERTY

201. SIGNATURE OF HONOR

202. SIGNATURE OF DISHONOR

203. SIGNATURE OF GLORY

204. SIGNATURE OF SHAME

205. SIGNATURE OF PRAISE

206. SIGNATURE OF REPROACH

207. SIGNATURE OF FAME

208. SIGNATURE OF OBSCURITY

209. SIGNATURE OF RESPECT

210. SIGNATURE OF CONTEMPT

211. SIGNATURE OF ADMIRATION

212. SIGNATURE OF DERISION

213. SIGNATURE OF REVERENCE

214. SIGNATURE OF DESPISE

215. SIGNATURE OF WORSHIP

216. SIGNATURE OF BLASPHEMY

217. SIGNATURE OF OBEDIENCE

218. SIGNATURE OF DISOBEDIENCE

219. SIGNATURE OF PATIENCE

220. SIGNATURE OF IMPATIENCE

221. SIGNATURE OF MILDNESS

222. SIGNATURE OF HARSHNESS

223. SIGNATURE OF SWEETNESS

224. SIGNATURE OF BITTERNESS

225. SIGNATURE OF LIGHTNESS

226. SIGNATURE OF HEAVINESS

227. SIGNATURE OF FREEDOM

228. SIGNATURE OF SLAVERY

229. SIGNATURE OF VICTORY

230. SIGNATURE OF DEFEAT

231. SIGNATURE OF TRIUMPH

232. SIGNATURE OF DISASTER

233. SIGNATURE OF SUCCESS

234. SIGNATURE OF FAILURE

235. SIGNATURE OF HAPPINESS

236. SIGNATURE OF UNHAPPINESS

237. SIGNATURE OF JOY

238. SIGNATURE OF GRIEF

239. SIGNATURE OF PEACE

240. SIGNATURE OF WAR

241. SIGNATURE OF LOVE

242. SIGNATURE OF HATE

243. SIGNATURE OF KINDNESS

244. SIGNATURE OF CRUELTY

245. SIGNATURE OF GENTLENESS

246. SIGNATURE OF RAGGEDNESS

247. SIGNATURE OF SMOOTHNESS

248. SIGNATURE OF CLEANLINESS

249. SIGNATURE OF DIRTYNESS

250. SIGNATURE OF ORDER

251. SIGNATURE OF DISORDER

252. SIGNATURE OF BEAUTY

253. SIGNATURE OF UGLINESS

254. SIGNATURE OF VIRTUE

255. SIGNATURE OF VICE

256. SIGNATURE OF GOODNESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03510

3547

CERTIFICATE OF DEATH

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 19 Yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 404 Walnut St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 404 Walnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arrilda First Fern Middle Rogers Last		4. DATE OF DEATH April 25 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1903
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph L. Wysell		14. MOTHER'S MAIDEN NAME Hattie Weyand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Dorsey Rogers	
17. INFORMANT Westernport, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral occlusion DUE TO 420,1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral artery disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 month 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 53 to April 25, 1956 , that I last saw the deceased alive on April 25 , 19 56 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westernport W. Va. DATE SIGNED 20			
ACTUAL SIGNATURE J. H. Wolverton Jr. M.D.		DATE SIGNED 20	
PHYSICIAN'S NAME (Type) J. H. Wolverton Jr. M.D.		ADDRESS Westernport W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Philos Cem.		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Brown ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR Ms Jean C Kelly DATE 4-28-56	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

3527

RECEIVED
BUREAU V. S.
 APR 30 1956

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS DIVISION OF VITAL RECORDS	
COUNTY OF ... STATE OF ...	
DECEASED'S NAME (Last, first, middle initial)	
SEX ... AGE ...	
DATE OF BIRTH ...	
PLACE OF BIRTH ...	
DATE OF DEATH ...	
PLACE OF DEATH ...	
CAUSE OF DEATH (as certified by physician)	
MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)	
SIGNATURE OF PHYSICIAN ...	
SIGNATURE OF REGISTRAR ...	
OFFICIAL USE ONLY	

3557 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Route # 220</u>		LENGTH OF STAY (in this place) <u>8 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural R #3 Keyser, W. Va.</u>			
TOWN <u>near Dawson, Md.</u>				TOWN <u>Rural R #3 Keyser, W. Va.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P. O. Address R 3 Keyser, W. Va.</u>				STREET ADDRESS (If rural give location) <u>Route #220 near Dawson, Md.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ezra Savage</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 10, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>March 7, 1882</u>	
				9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Savage</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Dedrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-14-6484</u>		17. INFORMANT & ADDRESS <u>Elwood Carskadon, R #3 Keyser, W. Va.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/26</u> , 19 <u>56</u> , to <u>4/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>56</u> , and that death occurred at <u>9:45P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Ezra Savage</u>				ADDRESS (Street, city, town, state) <u>486 N. Centre St. Cumberland</u>		DATE SIGNED <u>4/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/13/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery, Garrett Co., Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>April 12, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1955

1. DEATH REGISTRATION NUMBER OR PREVIOUS

2. DATE OF DEATH

3. PLACE OF DEATH

4. NAME OF DECEASED

5. SEX

6. AGE

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF OTHER

19. SIGNATURE OF

20. SIGNATURE OF

21. SIGNATURE OF

22. SIGNATURE OF

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURE OF REGISTRAR

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF CLERK

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF INTERVIEWER

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1. NAME OF DECEASED

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3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURE OF REGISTRAR

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF CLERK

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

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1. NAME OF DECEASED

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4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURE OF REGISTRAR

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF CLERK

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

13. SIGNATURE OF BURIAL OFFICIAL

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1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURE OF REGISTRAR

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF CLERK

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF INTERVIEWER

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1. NAME OF DECEASED

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5. CAUSE OF DEATH

6. MANNER OF DEATH

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8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF CLERK

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF INTERVIEWER

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22. SIGNATURE OF

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SIGNATURE OF REGISTRAR

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF CLERK

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

13. SIGNATURE OF BURIAL OFFICIAL

14. SIGNATURE OF INTERVIEWER

15. SIGNATURE OF OTHER

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17. SIGNATURE OF

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19. SIGNATURE OF

20. SIGNATURE OF

21. SIGNATURE OF

22. SIGNATURE OF

BUREAU V. S.

APR 13 1956

RECEIVED

1956

3523

CERTIFICATE OF DEATH

03512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.				c. LENGTH OF STAY IN 1b 14yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md.				d. STREET ADDRESS 402 Grand Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 402 Grand Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hattie Elizabeth Saville				4. DATE OF DEATH Month Day Year April 27, 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1869	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) Hay, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Wolford				14. MOTHER'S MAIDEN NAME Elizabeth Henderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Eldridge P. Saville 402 Grand Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right Hemiplegia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 26, 1956 to Apr. 27, 1956 , that I last saw the deceased alive on Apr. 27, 1956 , and that death occurred at 8:35 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett M.D.				ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 4/30/56			
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-56		22c. NAME OF CEMETERY OR CREMATORY Salem Meth Cem.		22d. LOCATION (City, town, or county) (State) Salem, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James P. Schepell ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR APR 30, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3233

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12-1-28		MOBILE, ALA		5-6-68		MOBILE, ALA	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POSTMORTEM EXAMINATION		16. SIGNATURE OF PHYSICIAN	
None		Suicide		Suicide		None		None		None		None		None	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CORONER		21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE		23. SIGNATURE OF CLERK		24. SIGNATURE OF DEPUTY CLERK	
None		None		None		None		None		None		None		None	

BUREAU V. 3

MAY 1 1956

RECEIVED

1
Within corporate limits

3524

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03513

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>17 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry James</u> Middle <u>Short</u> Last <u>Short</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3-1911</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>All. Ballistic Lab. Keyser, W. Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Marion Short</u>				14. MOTHER'S MAIDEN NAME <u>Ada Pyles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-10-4661</u>			
17. INFORMANT <u>daughter) Betty Lou Proud, Cumberland, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary (sclerosis) occlusion (left)</u> <u>420.1</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u>Coronary Osteal occlusion (right)</u> stating the underlying cause lost. <u> </u> Terminal <u> </u> Interval between onset and death <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 26-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 28, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Maryland.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>April 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, including the word "pending," in pencil in Item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOURS	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
FINDINGS		OPINION		REMARKS		SIGNATURE		DATE	

RECEIVED
APR 30 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3525

CERTIFICATE OF DEATH

Reg. Dist. No. 03514

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY	
c. LENGTH OF STAY IN 1b 3 DAYS		d. STREET ADDRESS 18 PERRY ST	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle SPRIGGS Last SPRIGGS		4. DATE OF DEATH Month APRIL Day 19 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 8 1887
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR. Westernport, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN SPRIGGS		14. MOTHER'S MAIDEN NAME Augusta Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-14-2333	
17. INFORMANT Mrs. Mary Spriggs, Ridgeley, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSES DUE TO ARTERIOSCLEROSIS, General Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COR PULMONALE, CHRONIC (c) PULMONARY Emphysema + Fibrosis		INTERVAL BETWEEN ONSET AND DEATH 1 month 5 years 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY Emphysema + Fibrosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , to APRIL 19, 1956 , that I last saw the deceased alive on APRIL 18, 1956 , and that death occurred at 9:25A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewensman		ADDRESS (Street, city or town, state) 59 Greene St	
PHYSICIAN'S NAME (Type) S. G. Weisman, M.D.		DATE SIGNED Cumberland Ind	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21 1956	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Am H. Right		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR April 20, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

APR 23 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3558 CERTIFICATE OF DEATH

03515

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Marys Terrace		d. STREET ADDRESS St. Marys Terrace	
3. NAME OF DECEASED (Type or print) First Anna Middle Reid Last Stakem		4. DATE OF DEATH Month 4 Day 25 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb, 1st. 1868
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR: Months 12 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Reid	
14. MOTHER'S MAIDEN NAME Mary Sloan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Bonig, Lonaconing, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 d 10 y.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1952 to April 1956 that I last saw the deceased alive on 25 April 1956 and that death occurred at 12:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George Eichhorn		ADDRESS (Street, city or town, state) 51 Main Lonaconing MD DATE SIGNED 4-26-56	
PHYSICIAN'S NAME (Type) George Eichhorn			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/1956	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, MD.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	
24a. REC'D BY REGISTRAR 4-27-56		24b. REGISTRAR'S SIGNATURE Jeannette M Boel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED George Nicholas		SEX Male		AGE 64	
DATE OF DEATH April 30, 1956		PLACE OF DEATH St. Mary's Hospital		CITY Baltimore	
OCCASION OF DEATH Heart Disease		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
DECEASED'S RESIDENCE 1000 North Avenue		DECEASED'S OCCUPATION Teacher		DECEASED'S MARITAL STATUS Married	
DECEASED'S BIRTH DATE May 1, 1892		DECEASED'S BIRTH PLACE Baltimore, Md.		DECEASED'S RACE White	
DECEASED'S RELIGION Roman Catholic		DECEASED'S EDUCATION High School Graduate		DECEASED'S SERVICE None	
DECEASED'S SIGNATURE George Nicholas		DECEASED'S ADDRESS 1000 North Avenue		DECEASED'S PHONE None	
DECEASED'S SOCIAL SECURITY NUMBER 1-123-456789		DECEASED'S MOTHER'S MARRIAGE LICENSE None		DECEASED'S MOTHER'S DEATH CERTIFICATE None	
DECEASED'S MOTHER'S NAME Mary Nicholas		DECEASED'S MOTHER'S BIRTH DATE May 1, 1892		DECEASED'S MOTHER'S BIRTH PLACE Baltimore, Md.	
DECEASED'S MOTHER'S OCCUPATION Teacher		DECEASED'S MOTHER'S MARITAL STATUS Married		DECEASED'S MOTHER'S SERVICE None	
DECEASED'S MOTHER'S SIGNATURE Mary Nicholas		DECEASED'S MOTHER'S ADDRESS 1000 North Avenue		DECEASED'S MOTHER'S PHONE None	
DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER 1-123-456789		DECEASED'S MOTHER'S MARRIAGE LICENSE None		DECEASED'S MOTHER'S DEATH CERTIFICATE None	
DECEASED'S MOTHER'S NAME Mary Nicholas		DECEASED'S MOTHER'S BIRTH DATE May 1, 1892		DECEASED'S MOTHER'S BIRTH PLACE Baltimore, Md.	
DECEASED'S MOTHER'S OCCUPATION Teacher		DECEASED'S MOTHER'S MARITAL STATUS Married		DECEASED'S MOTHER'S SERVICE None	
DECEASED'S MOTHER'S SIGNATURE Mary Nicholas		DECEASED'S MOTHER'S ADDRESS 1000 North Avenue		DECEASED'S MOTHER'S PHONE None	
DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER 1-123-456789		DECEASED'S MOTHER'S MARRIAGE LICENSE None		DECEASED'S MOTHER'S DEATH CERTIFICATE None	

RECEIVED
 APR 30 1956
 BUREAU V. S.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. ONLY. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL BUREAU OF INVESTIGATION OR THE UNITED STATES DEPARTMENT OF JUSTICE.

3526

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/9/53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 214 Hay Street	
3. NAME OF DECEASED (Type or print) First Charles Middle R. Last Steward		4. DATE OF DEATH Month April Day 3 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/1906
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - handicapped as a child.		10b. KIND OF BUSINESS OR INDUSTRY Keyser, W. Va.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. J. Steward		14. MOTHER'S MAIDEN NAME Josephine Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Allegany County Infirmary Records		Address P. O. Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO Chronic Hepatitis (c) Cerebral Edema?		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Edema?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 9th, 1953 to Apr. 4th, 1956 , that I last saw the deceased alive on Apr. 3rd, 1956 , and that death occurred at 12:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St.	
DATE SIGNED 4-4-56			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Bafer, Cumberland, Md.		ADDRESS April 6, 1956	
24a. REC'D BY REGISTRAR W.R. Frantz, M.D.		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3833

Allegany

Allegany

Allegany

Allegany

120073

Allegany

Allegany County, Indiana

Charles Steward

White

Male

None - handled as a child

William E. Steward

Josephine Dawson

Allegany County, Indiana

BUREAU V. S.

APR 9 1956

RECEIVED

3527

CERTIFICATE OF DEATH

03517

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 1Hr 20 Min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Orleans d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy Swain -TWIN#1				4. DATE OF DEATH Month April Day 22 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/22/56	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Mins 1 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME Novella N. Swain				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Patient's Chart.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inefficient Maturity of Vital Structures 759.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 April 1956 to 22 April 1956 , that I last saw the deceased alive on 22 April 1956 , and that death occurred at 6:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 800 Green St., Cumberland, Md. DATE SIGNED 23 April 56							
ACTUAL SIGNATURE Leland B. Ransom				M.D. M.D.			
PHYSICIAN'S NAME (Type) Leland B. Ransom, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/56		22c. NAME OF CEMETERY OR CREMATORY Allegany County Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm H. Right				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Wm H. Right	
				DATE April 24, 1956		24b. REGISTRAR'S SIGNATURE Wm H. Right, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 25 1956

RECEIVED

3528

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> Allegany b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 Hr. 40 Min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl Swain</u>			Last <u>TWIN #2</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 56</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/56</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Novella Swain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Insufficient maturity of vital structures</u> <u>759.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3hr - 10min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/22/56</u> , 19 <u>56</u> , to <u>4/23/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/22/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leland B. Ransom</u> M.D.				ADDRESS (Street, city or town, state) <u>63 Green St., Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Leland B. Ransom, M.D.</u>				DATE SIGNED <u>4/24/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/24/56</u>		<u>Allegany County Cem.</u>		<u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Knight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>April 24, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. K. Frantz, M.D.</u>			

Within corporate limits

Page 4

24 hours after death

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

3528

BUREAU V. S.

FR 25 1956

RECEIVED

3529

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 628. Lincoln St		d. STREET ADDRESS 628. Lincoln St	
3. NAME OF DECEASED (Type or print) First Charles (Chuck) Middle F. Last Swarner		4. DATE OF DEATH Month April Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 27 1911
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 4 Days 5 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Inspector		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Springfield	
11. BIRTHPLACE (State or foreign country) Cumberland, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel A. Swarner		14. MOTHER'S MAIDEN NAME Agnes Irwin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-09-4955	
17. INFORMANT Mr. Wm. Swarner, Cumberland, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Exhaustion 4343 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor Pulmonale DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 months 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/29/52 19____, to 4/30/56 19____, that I last saw the deceased alive on 4/30/56 , 19____, and that death occurred at 1 p.m. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard J. Williams, M.D.		DATE SIGNED 5/1/56	
PHYSICIAN'S NAME (Type) Richard J. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1956	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md/	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 2, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MAY 4 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03520

3559

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Savage</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNA</u>		(Middle) <u>(BARTH)</u>		(Last) <u>UHL</u>		(Month) <u>April</u> (Day) <u>26</u> (Year) <u>19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>3-9-1871</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Barth</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bauer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Clinton Uhl, Charleston, W. Va.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Heart dilation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Heart disease</u>				<u>several years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>				<u>several years</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>April 26, 1956</u> , that I last saw the deceased alive on <u>April 25, 1956</u> , and that death occurred at <u>5-2</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L. Alan G. Murray</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland</u>		DATE SIGNED <u>End</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-28-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. George Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>4-28-1956</u>		REGISTRAR'S SIGNATURE <u>Veronica M. Dermott</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

per E.W.

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MAY 1 1952

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03521

3548 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
TOWN <u>Frostburg</u>		LENGTH OF STAY (In this place) <u>4 hrs.</u>		TOWN <u>Frostburg</u>		STREET ADDRESS (If rural give location) <u>166 W. Main St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>166 W. Main St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>FLORENCE (McKENZIE) WARNE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 5, 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-22-1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cletus McKenzie</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hetz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Stanley Warne, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				Surgical years <u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 5, 1956</u> , to <u>Apr 5, 1956</u> , that I last saw the deceased alive on <u>Apr 5, 1956</u> , and that death occurred at <u>4:04 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>100m c Lane MD</u>		M.D. <u>Frostburg MD</u>		ADDRESS (Street, city, town, state) <u>4-8-56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-5-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Avilton, Md.</u>	
24. REC'D BY REGISTRAR <u>4-5-56</u>		REGISTRAR'S SIGNATURE <u>Dr. Nancy N. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

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NOTIFICATION

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the office of the State Registrar of the Department of Health, Annapolis, Maryland, and to the office of the State Registrar of the Department of Health, Washington, D.C.

3530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Sacred Heart Hospital.				d. STREET ADDRESS 414 Park St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jack Middle Frank Last West				4. DATE OF DEATH Month April Day 18 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19-1905		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur & laborer		10b. KIND OF BUSINESS OR INDUSTRY C. Cement & Supply		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Micheal Laminsky				14. MOTHER'S MAIDEN NAME Katie (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-12-6960		17. INFORMANT Address (wife) Ruby Virginia West, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombous 420.1 DUE TO Coronary sclerosis (right) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema DUE TO Cardiac hypertrophy (moderate) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH sudden several yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 18-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) near Hyndman, Pennsylvania.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Cumberland, Maryland.				24a. REC'D BY REGISTRAR April 19, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

3530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3531

CERTIFICATE OF DEATH

03523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>507 Cumberland St.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> <u>M. Wildes</u> <u>3rd</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1952</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward M. Wildes</u> <u>2nd</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Walsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Edward M. Wildes</u> , <u>Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Palsy</u> DUE TO <u>292.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>KERN icterus secondary to hemolytic</u> (c) <u>INANITION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>3 yrs</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH, 1956</u> , to <u>APRIL</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>APRIL 9, 1956</u> , and that death occurred at <u>8:15AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Devers</u> M.D.		DATE SIGNED <u>March 13, 1956</u>	
PHYSICIAN'S NAME (Type) <u>John C. Devers</u>		<u>Frostburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 14, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		22d. LOCATION (City, town, or county) (State) <u>Plains, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>Mar 13 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W.R. Hantz, M.D.</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

APR 13 1956

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>5 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100. Mullen Street</u>				d. STREET ADDRESS <u>100. Mullen Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jackqelena</u> Middle <u>Willis</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17 1877</u>		9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own House</u>		11. BIRTHPLACE (State or foreign country) <u>Grafton, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Woodyard</u>				14. MOTHER'S MAIDEN NAME <u>Anna Barbee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. W.L. Ranck, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis senile</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis, Chronic</u> DUE TO (c) <u>Uremia acute</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs -</u> <u>70 days</u> <u>90 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 12, 1956</u> to <u>April 25, 1956</u> ; that I last saw the deceased alive on <u>April 25, 1956</u> , and that death occurred <u>about 5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.M. Haskins Jr.</u>				M.D. <u>44 Green St</u>			
PHYSICIAN'S NAME (Type) <u>L.B. Matthews M.D.</u>				<u>Cumberland Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newark, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Right</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>April 26, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3582

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. DATE OF REGISTRATION [Faint text]</p>	

BUREAU V. S.

APR 27 1956

RECEIVED

DR. W.F. WILLIAMS 3533

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANN Middle GERTRUDE Last WILSON		4. DATE OF DEATH Month APRIL Day 19 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1906
9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress at home - Sewing for individuals		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G. EMORY WILSON		14. MOTHER'S MAIDEN NAME ELIZABETH SCHRIVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-20-5966	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis (uremia) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4:17 , 19 56 , to 4:19 , 19 56 that I last saw the deceased alive on 4:19 , 19 56 , and that death occurred at 11:40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W.F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 4:20.56	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4/23/56	St. Peter + Paul	Cumberland MD
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. MD		24a. REC'D BY REGISTRAR April 23, 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE W.R. Hantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DR. W. F. WILSON

MAXIMILIAN STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

ALLEGEDLY

MARYLAND

RESIDENCE

ALLEGEDLY

OF DEATH

2 DAYS

DECEASED

100 WEST 11 STREET

MEMORIAL HOSPITAL

APRIL 18

WILSON

CERTIFIED

AGE

SEX

SEPT. 1, 1950

WHITE

MALE

ELIZABETH A. WILSON

DR. W. F. WILSON

MEMORIAL HOSPITAL - BALTIMORE, MD.

100 WEST 11 STREET

BUREAU V. 8

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03526
DR. SIMONS 3534 CERTIFICATE OF DEATH										Reg. Dist. No. 4
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND					c. LENGTH OF STAY IN 1b 92 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, rural
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL					d. STREET ADDRESS RT. #2, BALTIMORE PIKE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First M. Margaret AMANDA Middle WILSON Last					4. DATE OF DEATH Month APRIL Day 23 Year 1956					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 29 1907		9. AGE (In years (last birthday) yrs.) 49		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at home					10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE C. GROSS					14. MOTHER'S MAIDEN NAME AMELIA RICE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL MEMORIAL AVENUE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.6 Carcinoma Spine + lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1955, to 4/23, 1956, that I last saw the deceased alive on 4/23, 1956, and that death occurred at 12:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE George M. Simon M.D. 128 Union St, Cumberland Md. 4/24/56 PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4/25/56		22c. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cemetery			22d. LOCATION (City, town, or county) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox					ADDRESS Cumberland, Md.		24. REC'D BY REGISTRAR DATE April 25, 1956		24b. REGISTRAR'S SIGNATURE Walter R. Hantz, MD	

CERTIFICATE OF DEATH

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BUREAU V. S.

APR 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03527

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>50</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>105 South George St.</u>				d. STREET ADDRESS <u>105 South George St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>W.</u> Last <u>Wiltison</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17-1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House painter</u>		11. BIRTHPLACE (State or foreign country) <u>Springfield, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edmond Wiltison</u>				14. MOTHER'S MAIDEN NAME <u>Clara Matchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-26-9753</u>		17. INFORMANT Address <u>(brother) James Wiltison, Burlington, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> 976x DUE TO (b) <u>a 32 caliber revolver wound in right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>temporal region. (Self inflicted)</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot himself with a 32 caliber revolver.</u>			
20c. TIME OF INJURY Month, Day, Year <u>6</u> <u>4-15</u> <u>1956</u> Hour <u>8:30</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Cumberland</u> (County) <u>Allegany</u> (State) <u>Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 16-1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-19-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burlington Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Burlington, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>April 18, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank M.D.</u>	

RECEIVED
APR 20 1956
BUREAU V. S.

03528

DR. JACOBSON

3536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 7HRS. 40 MINS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 612 MONTGOMERY AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA F. WITHERUP		4. DATE OF DEATH Month APRIL Day 9 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1893
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ex. Secy. American Red Cross		10b. KIND OF BUSINESS OR INDUSTRY OHIO	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES O'DONNELL		14. MOTHER'S MAIDEN NAME ANN WHITE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-7108	
17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVE.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left Ventricular Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Anterior Myocardial Infarction DUE TO (c) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH instant 12 hours 12 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1956 , to April 9, 1956 , that I last saw the deceased alive on April 9, 1956 , and that death occurred at 4:55 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street, Cumberland, Md. DATE SIGNED 4-9-56 ACTUAL SIGNATURE Samuel M. Jacobson M.D. PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/12/56	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		24a. REC'D BY REGISTRAR Phil 12, 1956	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE W. B. Frank, M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the [redacted] hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

APR 13 1956

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